

Appendix E

Massachusetts Cancer Registry

Automated Edits Reference Guide

NAACCR Layouts 9 and 9.1; EDITS version 9A

November 2001

INTRODUCTION

The EDITS Edits System

The Massachusetts Cancer Registry (MCR) uses automated (computerized) edits as part of our quality assurance efforts. These edits originate in the "EDITS" software system developed by the Centers for Disease Control and Prevention. The North American Association of Central Cancer Registries (NAACCR) promotes the use of the EDITS system to help central registries improve their data quality and meet required NAACCR data standards.

The edits themselves come from the standard-setting organizations like the SEER program, COC and NAACCR. Each of these groups, having different data needs and (sometimes) different requirements for the same data, have contributed slightly different versions of some edits. Registries may choose which edits and edit versions within the EDITS system that they wish to use to check their data by creating their own sets of edits to run. Most of the data fields collected by SEER, COC and NAACCR registries have at least one edit to check them. There are hundreds of standard edits from which to choose. The MCR has also created some specialized edits for our own use, and has modified some of the other groups' edits to better check MCR data. (The names of these edits usually include "MCR" or "MCR-CIMS".) We collect about 100 data fields and use about 200 automated edits. The MCR runs edits in "batch mode", i.e., we run the edits on batches of finished case records. Edits from the EDITS system may also be run "interactively", i.e., during data entry as fields are filled.

Automated edits are a useful tool for quickly checking the data quality of large numbers of case records. A case record that passes all automated edits, however, may still contain problems. Even if a registry were to run one version of each of the hundreds of edits available in the EDITS system, its data quality would not necessarily be perfect. Automated edits can only check coded fields easily; they do not "read" narratives, even to search for certain key words; they do not interpret or make decisions; they cannot replace the careful review of a knowledgeable registrar.

MCR Edit Reports

Automated edits are used at different points during MCR operations. When a floppy diskette is received from one of our reporting facilities, the case records are first "scanned" to see if the data are in the correct file format (NAACCR Case Record Layout 9 or 9.1) to be used by our data system, the Massachusetts Cancer Registry - Cancer Information System (CIMS). If the format is correct, a set of automated edits are then used to test the quality of the data. We call this set of edits the "Scan Edit Set". A printed edit report identifies case records that have not passed at least one edit, the names of the edits that were not passed for each case record, and the total number of times each edit failed in the whole data submission. A copy of this edit report is sent back to the reporting facility. If too many problems are detected by this process, the MCR may reject the entire data submission.

If the data submission is accepted, the case records are uploaded into the Holding Database of our data system. When the case records are processed by MCR staff, another set of edits is run to identify problems. We call this set of edits our Production Edit Set (it is almost identical to the Scan Edit Set). Our staff also visually review the cases to look for problems that the automated edits do not check, and text fields (narratives) are read and compared with coded fields. A case record cannot be saved into our main (Master) database until it has passed all of our automated edits and has been visually reviewed. Certain edits in the Production Edit Set identify diagnoses that are not reportable to the MCR, were diagnosed before 1995, or occurred in non-Massachusetts residents. Such cases are not allowed into our Master Database, but they are flagged appropriately and remain in our Holding Database.

When you receive an edit report from the MCR, we hope that this Appendix will help you determine what may have been questionable or incorrect in your data submissions. You may later receive additional feedback about your data quality from our staff as they process and visually review your case records.

The NAACCR 9 and 9.1 Layouts

The MCR accepts case records in the NAACCR Case Record Layout Versions 9 or 9.1 ("V9.1"). These layouts are intended for cases diagnosed in 2001 and 2002 respectively, and may also be referred to as the "2001" or "2002" NAACCR formats or layouts. A case record in V9.1 (or 9) layout contains a total of 5966 characters in more than 300 data fields. The value for each field is kept in an assigned location within the layout. For example, the 2-digit code for Primary Payer at Diagnosis is kept in the 329th and 330th character positions (columns). There are no physical differences between Versions 9 and 9.1 -- all of the fields are in the same places in both Versions. When you create a data file for submission to the MCR, your data system outputs the case records in V9.1 (or 9) by selecting the appropriate fields and placing them in the proper locations. This process is probably invisible to you.

The MCR only collects about 100 data fields from the V9.1 layout. Our data system searches your outputted case records by looking in the appropriate locations to find the fields that we want. For example, our system selects the 329th and 330th characters from each of your case records and copies them into our Primary Payer at Diagnosis field. If your data system does not have certain fields that the MCR collects, your system should fill these fields with something automatically when you create your MCR data file.

If your case records do not come out of your system in Version 9.1 (or 9) layout, our system will not be able to process them and the data will be rejected. If a data field ends up in the wrong place within the case records that you send us, or if our data system looks in the wrong location to find some data field, then the data that we see at the MCR may not make sense. Having all of the fields in exactly the correct locations is crucial.

How to Use This Appendix

When you receive an edit report from the MCR, you may need help in understanding what was questionable or incorrect in your case records. Each edit that appears on your edit report has a certain name in our Scan Edit Set. The edit names are listed alphabetically on pages 7-10 in this Appendix with the page number where a description of each edit can be found. Each edit is also given a "MCR Edit #"; if you have questions about a particular edit, it may be easier to refer to this number rather than the long edit name when talking to us.

When a case record has failed an edit, the edit report lists the name of each data field involved in that edit. These are the V9.1 field names. If you are not familiar with a field name or are not sure of the corresponding field in your data system, each field name is listed alphabetically on pages 11-13 of this Appendix with its Item # in V9.1 and its starting and ending positions in the V9.1 layout. The corresponding fields in the MCR Abstracting and Coding Manual and ROADS Manual are given. The ROADS field names reflect changes issued by the ACoS in their "Surgery Code Clarifications", last revised on March 16, 2000. Within the main body of the MCR Manual, each field is also listed with its V9.1 name (if different than the MCR name), Item # and position.

The edits that involve each field are listed on pages E-17-22 in this Appendix. The fields are listed alphabetically by their V9.1 names. The validity check or character check on each field is listed first, followed alphabetically by any other edits that involve that field. The number next to each edit name is the MCR Edit #.

Pages E-7-10 in this Appendix provide the page where each edit's description can be found. The edit descriptions begin on page E-25, ordered alphabetically by edit name. The edit names are bold. All fields involved with the edit are listed, using their V9.1 names. For single-field edits, that field's length follows its name.

When you have a question about why a case record failed a certain edit, consult the edit's description. Use pages E-13-16 if you're not sure about the field(s) involved. Some terms and symbols used in the edit descriptions may be unfamiliar and are included on pages E-3-4.

Edit reports include the value (usually a code) that our data system found in each data field involved in each edit. If the value for a field shown on your edit report differs from the value you find on your data system, there may be a problem with your data system or ours; or the field may have been changed on your system after the case record was sent to the MCR.

Strange Terms/Definitions Used in this Appendix

blank check	not a generous gift; rather, an edit that checks whether a data field is empty or not; a blank check fails if the field is empty when it should contain something
blank-filled	when a filled-in data field does not contain enough characters to fill it completely, your data system may automatically fill the remainder of the field with blanks; example -- the AJCC Clinical Stage Group field must contain 2 characters, so if you fill in only the first character, your system may fill the second character in with a blank space for you because the field must be completely filled
case record	the electronic version of a MCR Cancer Patient Abstract; a data record that contains the data pertaining to one cancer case; 5966 characters long in V9.1
character check	an edit that checks the type of characters in a data field; if a field should only contain a number, for example, a character check run on that field would fail if the field contained a letter, punctuation mark, etc.
data field	also known as a data item or just "field"; a particular category of data within a data table, database or data record (row in a data table); for example, in a MCR case record, there are data fields that contain codes for "Place of Death" and "Birth Place"
digit	a single number (0-9)
embedded hyphen	a hyphen (dash) (-) in a data field that is not the first character in the field; in "A-B", the hyphen is embedded
embedded space	a space character (as when you have hit the spacebar on a keyboard) within a data field that is not the first character in that field; if a field contains a_b , there is an embedded space between the a and b characters
empty field	when nothing whatsoever is in a data field, it is empty; we try to avoid calling this a "blank field" because that could imply that blanks (spacebars) have been entered into it or that it was automatically blank-filled
error message	a short phrase that is produced automatically when an edit fails; the message may indicate what the edit found and did not like about the data being checked; some edits produce several different error messages, depending on exactly what problem was detected
field	same as data field
leading space	a space character that is the first character in a data field; if a field contains _2 , the 2 is preceded by a leading space
length	the number of characters that fill a data field completely; the MCR data field for patient's age, for example, is 3 digits long; the field for patient's usual occupation has a 40-character length
look-up table	when an edit is checking for certain values in a data field and the number of acceptable values for the field is very lengthy, those acceptable values may be stored in a data table in the EDITS system rather than within the edit itself; for example, the many standard codes for "Place of Birth" are kept in a look-up table, while the 2 standard codes for "Vital Status" are written right into its validity check

V9.1	the North American Association of Central Cancer Registries Case Record Layout Version 9 or 9.1; these layouts date from May 2000 (with errata issued August 2000) and March 2001; may also be called the "2001" and "2002" formats because they are meant to apply to cases diagnosed in 2001 and 2002, respectively; a case record in V9.1 format contains 5966 characters
over-ride	a way to bypass a certain edit or edits for a case record by using "flag" fields; if the over-ride flag associated with an edit contains a certain value (usually 1), that edit skips that case record; example -- if a prostate cancer is diagnosed in a very young man, and if the edit named "Age, Primary Site, Morphology (NAACCR IF15)" finds its over-ride flag field empty, it will ask that the coding of the case be double-checked; if the age and diagnosis are correct, check the appropriate flag on your system to over-ride the edit; when the edit runs again on that case, the edit will see a 1 in its flag field and will then stop checking that case record
symbol	any keyboard character that is not a letter or number
validity check	an edit that compares the contents of a single data field with a set of acceptable standard codes; it fails when the field's contents do not match one of the acceptable codes; the validity check on Vital Status checks that the field contains either 0 or 1 , for example

Standard Symbols Used Strangely in this Appendix

- > "is greater than"
example: "Histologic Type > **8790**" means "The Histologic Type Code has a value greater than **8790**."
- < "is less than"
example: "Histologic Type < **9590**" means "The Histologic Type Code has a value less than **9590**."
- ≥ "is greater than or equal to"
example: "Histologic Type ≥ **9590**" means "The Histologic Type Code has a value of at least **9590**."
- ≤ "is less than or equal to"
example: "Histologic Type ≤ **9804**" means "The Histologic Type Code has a value of **9804** at most."
- "through...inclusive"
example: "Behavior = **0 - 3**" means "The Behavior Code has a value of **0, 1, 2 or 3**."
- = "is equal to" or "may be equal to"
example: "Laterality = **0 - 4 or 9**" means "The Laterality Code has a value of **0, 1, 2, 3, 4 or 9**."
- ⋈ "is not equal to"
example: "Behavior Code ⋈ **0 or 1**" means "The Behavior Code has a value that is neither **0** nor **1**."
- _ a space character, as in the (usually) invisible character produced when you hit the spacebar on a keyboard;
example: **1_** indicates that there are two characters here -- a code **1** followed by a space; it does not indicate a code **1** followed by an underlined space.

Types of Edits

Single-Field Edits

A single-field edit examines the contents of one data field only.

Some edits are described as “blank checks”. This type of edit merely checks whether a data field is blank (empty) or contains something. None of the MCR’s coded fields should be empty. The only narrative (free text) fields which may be empty are the Comments/Narrative Remarks field, treatment narratives for which that type of therapy was not performed during the first course of treatment, and Staging Narratives if they do not apply to a certain case. For nonanalytic cases, all narrative fields may be empty. To avoid leaving fields empty, use unknown/not applicable codes and the text “Unknown” as necessary.

Some single-field edits are “character checks”. This kind of edit examines the type of characters entered into a field. It may check if each character is a letter, number, space, or symbol (all of the other characters on a keyboard, like !@#\$%<>?.,:;)). For example, there is an edit which checks if the Middle Name field contains anything but letters.

Most single-field edits are “validity checks”. Each of these looks for certain values in a field; anything else found in the field will cause the edit to fail. For example, the validity check on Vital Status only accepts the codes **0** or **1**. Validity checks on date fields are more complex because different values for day, month and year must be evaluated, and the entire date as a whole is also checked.

Interfield and Multifield Edits

These more complex edits check the values in two or more fields at once. These edits are looking for incompatibility among the codes in different fields. For example, an interfield edit between the fields Vital Status and Place of Death checks that a patient is not coded as “alive” and coded as having died somewhere within the same case record.

Unlike single-field edits, these edits are not implying that there is an error in any one field. They are saying, “The codes in these fields don’t make sense together. One or all of them may be wrong.”

Many interfield and multifield edits are set to skip over a case record if the fields involved contain invalid codes or empty fields. For example, if a case record contains a bad Behavior Code of “8”, then many of the interfield and multifield edits that involve Behavior will not bother to check that case. Suppose edits are run on a case and there is only one error reported -- an invalid Primary Site Code. If you fix that one bad code and re-run the edits, you may find that there are several new errors reported -- because the many multifield edits involving Primary Site Code did not touch the case before. This is why edits should be re-run whenever changes are made in a case. Furthermore, changing the value in one field to satisfy one edit may then cause a different edit to complain.

Inter-Record Edits

This type of edit looks at codes in two or more cases at once. For example, if you have a patient on your data system recorded with two primary tumors, you might use an inter-record edit to check that the patient’s gender is coded consistently in both records; another inter-record edit might check that the two diagnoses are not considered a single primary. Although the SEER registries have experience running edits between case records, there are no such edits in the EDITS system. The MCR occasionally runs some SEER inter-record edits outside the EDITS system, but not on incoming data from our reporting facilities.

Pass/Fail/Skip, Warnings and Error Messages

Most edits are “pass/fail”. That is, the edit checks the appropriate field(s) in a case record and the edit either passes or fails for that case. An edit may begin to check a record, detect a certain code that tells it to not bother checking any further, and then immediately halt and “skip” that record.

Some edits may pass, fail or produce a “warning” instead of failing. When the edits are run, these may be set to produce warnings instead of failures. The MCR sets its edit reports to suppress warnings (i.e., to produce failures rather than warnings).

When an edit fails for a case record, an “error message” is produced. This message is an English phrase and will appear when an edit report is printed. The error messages are supposed to provide some indication of what the edit did not like about the case, although sometimes they are not much help in figuring out what is wrong. Some edits will produce one of several different error messages, depending on exactly what type of problem was found.

Over-Rides

The failure of a few interfield edits can be over-ridden. When these edits fail, they are not indicating that something is definitely wrong with the case. They are instead saying, “I question this combination of codes. It’s very unusual.” Someone must examine the fields in question and change or verify them. If the codes entered are indeed correct, an “over-ride flag” field can be used to make the edit pass.

For example, an over-rideable edit compares a patient’s age with his/her diagnosis. If a 40-year old man has prostate cancer, this edit will question this combination because he's unusually young for this disease. If the age and diagnosis are indeed accurate, the over-ride for this edit can be set so that the edit will pass the case.

The edits that can be over-ridden look at the codes in certain fields (over-ride “flags”) within the case record itself to decide if they have been over-ridden or not for that case. Once an edit is over-ridden for a case, it will continue to always pass that case unless someone changes its over-ride flag to cause the edit to fail again. Even if you have set over-ride flags on your data system to pass certain edits for certain cases, the MCR cannot “take your word” automatically that those flags should really have been set. We must verify unusual code combinations ourselves and set our own over-ride flags appropriately on our system. We rely on remarks in Narrative fields to confirm that *you* have indeed verified any unusual code combinations at your facility. We do not look at the over-ride flags you have set when we see your cases!

NAACCR 9A Automated Edits
Being Run by the Massachusetts Cancer Registry
sorted by Name of Edit

November 2001

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**Data Fields Collected by Massachusetts Cancer Registry from NAACCR V9.1 Layout
and Corresponding Fields in MCR and ROADS Manuals**

(arranged alphabetically by V9.1 field name*)

November 2001

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Date Case Completed	2090	952-959	Date Case Completed, p. 183	not in ROADS
Date Case Report Exported	2110	968-975	Date Case Report Exported, p. 183	not in ROADS
Date Case Report Received	2111	996-1003	Date Case Report Received, p. 183	not in ROADS
Date of 1st Contact	580	300-307	Date of First Contact, p. 39	not in ROADS
Date of 1st Crs RX--COC	1270	593-600	Date of First Course Treatment -- COC, p. 152	Date of first course treatment, p. 179
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EOD--Lymph Node Involv	810	397	EOD -- Lymph Node Involvement, p. 145	Lymph nodes (SEER EOD), p. 128
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State/Requestor Items	2220	1026-1076	Managing Physician Name, p. 39	not in ROADS

* except State/Requestor Items is listed as if under MCR field name Managing Physician Name

<u>V9.1 Field Name</u>	<u>Item #</u>	<u>Position</u>	<u>Field in the MCR Manual</u>	<u>Field in the ROADS Manual</u>
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Name--Middle	2250	1565-1578	Patient Middle Name, p. 41	Middle name, p. 50
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RX Hosp--Chemo	700	352	Chemotherapy -- At This Facility, p. 172	Chemotherapy at this facility, p. 231
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RX Summ--Chemo	1390	628	Chemotherapy -- Summary, p. 172	Chemotherapy, p. 228
RX Summ--DX/Stg/Pall Proc	1350	623-624	Diagnostic/Staging/Palliative Procedures -- Summary, p. 154	Diagnostic, staging, or palliative procedures, p. 181
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RX Text--Chemo	2640	4197-4396	Chemotherapy -- Narrative, p. 172	not in ROADS
RX Text--Hormone	2650	4397-4596	Hormone Therapy -- Narrative, p. 175	not in ROADS
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Text--DX Proc--Path	2570	3117-3366	Text--Dx Proc--Path, p. 147	not in ROADS
Text--DX Proc--PE	2520	1917-2116	Text--Dx Proc--PE, p. 145	not in ROADS

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- field: **Accession Number--Hosp** (called Accession Number in MCR Manual)
 edits: none
- field: **Addr at DX--City** (called City / Town at Diagnosis in MCR Manual)
 edits: 2. Addr at DX--City (NAACCR) p. E-35
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- field: **Addr at DX--Postal Code** (called ZIP / Postal Code at Diagnosis in MCR Manual)
 edits: 3A. Addr at DX--Postal Code (NAACCR) p. E-35
 3B. Addr at DX--Postal Code (NAACCR/MCR-CIMS) p. E-35
 46. Invalid Zipcode (MCR-CIMS) p. E-54
- field: **Addr at DX--State** (called State at Diagnosis in MCR Manual)
 edits: 4. Addr at DX--State (NAACCR) p. E-35
 54. MCR-CIMS Master Db Edits p. E-58
- field: **Age at Diagnosis**
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 7. Age at Diagnosis, Text--Usual Industry (NAACCR/MCR) p. E-36
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field: **Class of Case**

edits: 18. Class of Case (COC) p. E-43
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field: **Date Case Completed**

edit: 21. Date Case Completed (MCR-CIMS) p. E-44

field: **Date Case Report Exported**

edit: 22. Date Case Exported (MCR-CIMS) p. E-44

field: **Date Case Report Received**

edits: none

field: **Date of 1st Contact** (called Date of First Contact in MCR Manual)

edit: 27. Date of Adm/1st Contact (NAACCR DATEEDIT) p. E-46

field: **Date of 1st Crs RX--COC** (called Date of First Course Treatment -- COC in MCR Manual)

- edits: 23. Date of 1st Crs RX--COC (COC) p. E-44
 24. Date of 1st Crs RX--COC, Date Last Contact (COC) p. E-45
 25. Date of 1st Crs RX--COC, Date of DX (COC) p. E-45
 26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46

field: **Date of Diagnosis**

- edits: 28. Date of Diagnosis (NAACCR DATEEDIT) p. E-46
 7. Age at Diagnosis, Text--Usual Industry (NAACCR/MCR) p. E-36
 8. Age at Diagnosis, Text--Usual Occupation (NAACCR/MCR) p. E-37
 9. Age, Birth Date, Date of Diagnosis (NAACCR IF13) p. E-37
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 13B. Behavior ICDO3, Date of Diagnosis (NAACCR) p. E-40
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 36A. EOD--Tumor Size, Primary Site (NAACCR) p. E-50
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 40A. Hematopoietic, TNM (NAACCR) p. E-52
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 56B. Morphology--Type&Behavior ICDO3 (SEER MORPH) p. E-61
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 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 78. Race 2, Date of DX (NAACCR) p. E-73
 80. Race 3, Date of DX (NAACCR) p. E-73
 82. Race 4, Date of DX (NAACCR) p. E-74
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 142. RX Summ--Scope Reg LN Sur,RX Summ--Reg LN Ex (NPCR) p. E-89
 155A. Summary Stage 2000, Date of Diagnosis (NAACCR) p. E-92
 155B. Summary Stage, Date of Diagnosis (NAACCR) p. E-96
 161. Summary Stage, Histology (COC) p. E-96
 177. Type of Report Srce(DC/AO), Date of Dx (SEER IF02) p. E-107
 183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109
 186. Year First Seen This CA, Date of DX (NAACCR) p. E-110

field: **Date of Last Contact**

- edits: 29. Date of Last Contact (NAACCR DATEEDIT) p. E-46
 20. Class, Date Diag, Date Last Cont, Vit Stat (COC) p. E-44
 24. Date of 1st Crs RX--COC, Date Last Contact (COC) p. E-45
 30. Date of Last Contact, Date of Diag. (NAACCR IF19) p. E-47
 177. Type of Report Srce(DC/AO), Date of Dx (SEER IF02) p. E-107

field: **Diagnostic Confirmation**

- edits: 31. Diagnostic Confirmation (SEER DXCONF) p. E-47
 32A. Diagnostic Confirmation, Behavior Code (SEER IF31) p. E-47
 32B. Diagnostic Confirmation, Behavior ICD03 (SEER IF31) p. E-48
 33A. Diagnostic Confirmation, Histologic Typ(SEER IF48) p. E-48
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 178. Type of Report Srce(DC/AO), Diag Conf (SEER IF05) p. E-108

field: **EOD--Extension**

edits: none

field: **EOD--Extension Prost Path** (called EOD -- Extension Prostate Pathology in MCR Manual)

edits: none

field: **EOD--Lymph Node Involv** (called EOD -- Lymph Node Involvement in MCR Manual)

edits: none

field: **EOD--Tumor Size**

- edit: 35. EOD--Tumor Size (NAACCR) p. E-50
 36A. EOD--Tumor Size, Primary Site (NAACCR) p. E-50
 36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR) p. E-51

field: **Grade** (called Grade / Differentiation / Immunophenotype in MCR Manual)

- edits: 37. Grade (COC) p. E-51
 56A. Morphology--Type&Behavior (SEER MORPH) p. E-59
 56B. Morphology--Type&Behavior ICDO3 (SEER MORPH) p. E-61

field: **Histologic Type ICD-O-3** (called ICD-O-3 Histologic Type Code in MCR Manual)

- edits: 41B. Histologic Type ICDO3 (COC) p. E-53
 56B. Morphology--Type&Behavior ICDO3 (SEER MORPH) p. E-61
 10B. Age, Primary Site, Morphology ICDO3 (NAACCR IF15) p. E-38
 12B. Behavior ICDO3, Histologic Type ICDO3 (NAACCR/MCR) p. E-41
 33B. Diagnostic Confirmation, Histology ICD03(SEER IF48 p. E-48
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 36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR) p. E-51
 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 43. Histology ICDO2, Histology ICDO3 (NAACCR) p. E-53
 42B. Histology ICDO3, Date of Diagnosis (NAACCR) p. E-53
 49A. Laterality, Primary Site, Morph ICDO3 (NAACCR IF42) p. E-56
 50. Lymphoma, Primary Site, Summary Stage (NAACCR) p. E-57
 51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
 55. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
 70B. Primary Site, Behavior Code ICDO3 (SEER IF39/MCR- p. E-65
 72A. Primary Site, Morphology-Imposs ICDO3 (SEER IF38) p. E-67
 73B. Primary Site, Morphology-Type ICDO3 (SEER IF25) p. E-70
 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 141B. RX Summ--Scope Reg LN Sur, Primary Site, ICDO3(COC) p. E-89
 157. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-93
 158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR) p. E-94
 164B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-102
 183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109

field: **Histology (92-00) ICD-O-2** (called ICD-O-2 Histologic Type Code in MCR Manual)

edits: 41A. Histologic Type (COC) p. E-53
 56A. Morphology--Type&Behavior (SEER MORPH) p. E-59
 10A. Age, Primary Site, Morphology (NAACCR IF15) p. E-37
 12A. Behavior Code, Histologic Type (NAACCR/MCR-CIMS) p. E-40
 33A. Diagnostic Confirmation, Histologic Typ(SEER IF48) p. E-48
 34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR) p. E-49
 36A. EOD--Tumor Size, Primary Site (NAACCR) p. E-50
 38. Hemato, Summ Stage, Class of Case (NAACCR) p. E-51
 39. Hemato, Summ Stage, Type of Report Srce (NAACCR) p. E-52
 40A. Hematopoietic, TNM (NAACCR) p. E-52
 42A. Histology ICDO2, Date of Diagnosis (NAACCR) p. E-53
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 49B. Laterality, Primary Site, Morphology (NAACCR IF42) p. E-57
 51A. Lymphoma, TNM (NAACCR) p. E-57
 55. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
 70A. Primary Site, Behavior Code (MCR-CIMS/SEER IF39) p. E-65
 72B. Primary Site, Morphology-Impossible (SEER IF38) p. E-69
 73A. Primary Site, Morphology-Type Check (SEER IF25) p. E-70
 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 141A. RX Summ--Scope Reg LN Sur, Primary Site (COC) p. E-89
 161. Summary Stage, Histology (COC) p. E-96
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 183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109

field: **ICD-O-3 Conversion Flag**

edits: 44. ICD-O-3 Conversion Flag (NAACCR)
 183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109

field: **Institution Referred From**

edits: none

field: **Institution Referred To**

edits: none

field: **Laterality**

edits: 47. Laterality (SEER LATERAL) p. E-54
 48. Laterality, Primary Site (NAACCR IF24) p. E-55
 49A. Laterality, Primary Site, Morph ICDO3 (NAACCR IF42) p. E-56
 49B. Laterality, Primary Site, Morphology (NAACCR IF42) p. E-57
 89. RML Lung, Laterality (NAACCR) p. E-76
 181. Unknown Site, Laterality (NAACCR) p. E-108

field: State/Requestor Items (**Managing Physician Name**)

edits: none

field: **Marital Status at DX** (called Marital Status at Diagnosis in MCR Manual)

edits: 52. Marital Status at DX (SEER MARITAL) p. E-58
 53. Marital Status at DX, Age at Diagnosis (SEER IF14) p. E-58

field: **Medical Record Number**

edits: none

field: **Name--Alias** (called Patient Alias Name in MCR Manual)

edit: 57. Name--Alias (COC) p. E-61

- field: **Name--First** (called First Name in MCR Manual)
 edit: 58. Name--First (MCR-CIMS) p. E-62
- field: **Name--Last** (called Last Name in MCR Manual)
 edit: 59. Name--Last (MCR) p. E-62
- field: **Name--Maiden** (called Maiden Name in MCR Manual)
 edit: 60. Name--Maiden (MCR-CIMS) p. E-62
- field: **Name--Middle** (called Middle Name in MCR Manual)
 edit: 61. Name--Middle (NAACCR) p. E-62
- field: **Name--Suffix** (called Name Suffix in MCR Manual)
 edit: 62. Name--Suffix (COC) p. E-63
- field: **Pediatric Stage**
 edits: 63. Pediatric Stage (NAACCR) p. E-63
 64. Pediatric Stage, Pediatric Staging System (COC) p. E-63
- field: **Pediatric Staging System**
 edits: 65. Pediatric Staging System (NAACCR) p. E-64
 64. Pediatric Stage, Pediatric Staging System (COC) p. E-63
- field: **Place of Death**
 edits: 66. Place of Death (NAACCR) p. E-64
 67. Place of Death, Vital Status (NAACCR) p. E-64
- field: **Primary Payer at DX** (called Primary Payer at Diagnosis in MCR Manual)
 edit: 68. Primary Payer at DX (NAACCR) p. E-64
- field: **Primary Site** (called Primary Site Code in MCR Manual)
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 10B. Age, Primary Site, Morphology ICDO3 (NAACCR IF15) p. E-38
 12A. Behavior Code, Histologic Type (NAACCR/MCR-CIMS) p. E-40
 12B. Behavior ICDO3, Histologic Type ICDO3 (NAACCR/MCR) p. E-42
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 34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR) p. E-49
 36A. EOD--Tumor Size, Primary Site (NAACCR) p. E-50
 36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR) p. E-51
 49A. Laterality, Primary Site, Morph ICDO3 (NAACCR IF42) p. E-56
 48. Laterality, Primary Site (NAACCR IF24) p. E-55
 49B. Laterality, Primary Site, Morphology (NAACCR IF42) p. E-57
 50. Lymphoma, Primary Site, Summary Stage (NAACCR) p. E-57
 55. MCR-CIMS (NOT REPORTABLE CASE) p. E-59
 70A. Primary Site, Behavior Code (MCR-CIMS/SEER IF39) p. E-65
 70B. Primary Site, Behavior Code ICDO3 (SEER IF39/MCR- p. E-65
 72A. Primary Site, Morphology-Imposs ICDO3 (SEER IF38) p. E-67
 72B. Primary Site, Morphology-Impossible (SEER IF38) p. E-69
 73A. Primary Site, Morphology-Type Check (SEER IF25) p. E-70
 73B. Primary Site, Morphology-Type ICDO3 (SEER IF25) p. E-70
 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
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- 113. RX Hosp--Scope Reg LN Sur, Primary Site (COC) p. E-82
- 117. RX Hosp--Surg Oth Reg/Dis, Primary Site(COC) p. E-83
- 120. RX Hosp--Surg Prim Site, Primary Site (COC) p. E-84
- 138. RX Summ--Reconstruct 1st, Primary Site (COC) p. E-88
- 141A. RX Summ--Scope Reg LN Sur, Primary Site (COC) p. E-89
- 141B. RX Summ--Scope Reg LN Sur, Primary Site, ICDO3(COC) p. E-89
- 144. RX Summ--Surg Oth Reg/Dis, Primary Site (COC) p. E-90
- 147. RX Summ--Surg Prim Site, Primary Site (COC) p. E-90
- 151. Sex, Primary Site (SEER IF17) p. E-91
- 157. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-93
- 158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR) p. E-94
- 164A. Surgery, RX Date--Surgery (COC) p. E-101
- 164B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-102
- 181. Unknown Site, Laterality (NAACCR) p. E-108
- 182. Unknown Site, Summary Stage (NAACCR) p. 109
- 183. Verify ICDO2 to ICDO3 Conversion (NAACCR) p. E-109

field: **Race 1**

- edit: 75. Race 1 (SEER RACE) p. E-72
 76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72

field: **Race 2**

- edit: 77. Race 2 (NAACCR) p. E-73
 76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
 78. Race 2, Date of DX (NAACCR) p. E-73

field: **Race 3**

- edit: 79. Race 3 (NAACCR) p. E-73
 76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
 80. Race 3, Date of DX (NAACCR) p. E-73

field: **Race 4**

- edit: 81. Race 4 (NAACCR) p. E-74
 76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
 82. Race 4, Date of DX (NAACCR) p. E-74

field: **Race 5**

- edit: 83. Race 5 (NAACCR) p. E-74
 76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR) p. E-72
 84. Race 5, Date of DX (NAACCR) p. E-74

field: **Reason For No Surgery**

- edits: 85. Reason for No Surgery (SEER NCDSURG) p. E-75
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field: **Regional Nodes Examined**

- edits: 87. Regional Nodes Examined (COC) p. E-76
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 34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR) p. E-49
 86. Regional Nodes Ex, Reg Nodes Pos (COC) p. E-75

- field: **Regional Nodes Positive**
 edits: 88. Regional Nodes Positive (COC) p. E-76
 34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR) p. E-49
 34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR) p. E-49
 86. Regional Nodes Ex, Reg Nodes Pos (COC) p. E-75
 156A. Summary Stage 2000, Regional Nodes Pos (NAACCR) p. E-93
 156B. Summary Stage, Regional Nodes Pos (NAACCR) p. E-97
- field: **Reporting Hospital** (called Facility Code in MCR Manual)
 edits: none (but must be the same for each case record in a data submission)
- field: **RX Date--BRM** (called Immunotherapy -- Date Started in MCR Manual)
 edits: 90. RX Date--BRM (NAACCR) p. E-76
 26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
 122. RX Summ--BRM, RX Date--BRM (COC) p. E-84
- field: **RX Date--Chemo** (called Chemotherapy -- Date Started in MCR Manual)
 edits: 91. RX Date--Chemo (NAACCR) p. E-77
 26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
 125. RX Summ--Chemo, RX Date--Chemo (COC) p. E-85
- field: **RX Date--DX/Stg/Pall Proc** (called Diagnostic/Staging/Palliative Procedures--Date Started in MCR Manual)
 edits: 92. RX Date--DX/Stg/Pall Proc (NAACCR) p. E-77
 128. RX Summ--DX/Stg/Pall, RX Date--DX/Stg/Pall Proc (NAACCR) p. E-86
- field: **RX Date--Hormone** (called Hormone Therapy -- Date Started in MCR Manual)
 edits: 93. RX Date--Hormone (NAACCR) p. E-77
 26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
 130. RX Summ--Hormone, RX Date--Hormone (COC) p. E-86
- field: **RX Date--Other** (called Other Cancer-Directed Therapy--Date Started in MCR Manual)
 edits: 94. RX Date--Other (NAACCR) p. E-77
 26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
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- field: **RX Date--Radiation** (called Radiation Therapy -- Date Started in MCR Manual)
 edits: 95. RX Date--Radiation (NAACCR) p. E-77
 26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
 136. RX Summ--Radiation, RX Date--Radiation (COC) p. E-88
- field: **RX Date--Surgery** (called Cancer-Directed Surgery -- Date Started in MCR Manual)
 edits: 96. RX Date--Surgery (NAACCR) p. E-77
 26. Date of 1st Crs RX--COC, Dates of RX (NAACCR) p. E-46
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 164A. Surgery, RX Date--Surgery (COC) p. E-101
 164B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-102
- field: **RX Hosp--BRM** (called Immunotherapy -- At This Facility in MCR Manual)
 edits: 97. RX Hosp--BRM (NAACCR) p. E-78
 98. RX Hosp--BRM, RX Summ--BRM (COC) p. E-78
- field: **RX Hosp--Chemo** (called Chemotherapy -- At This Facility in MCR Manual)
 edits: 100. RX Hosp--Chemo (NAACCR) p. E-78
 101. RX Hosp--Chemo, RX Summ--Chemo (COC) p. E-79

- field: **RX Hosp--DX/Stg/Pall Proc** (called Diagnostic/Staging/Palliative Procedures--At This Facility in MCR Manual)
 edits: 102. RX Hosp--DX/Stg/Pall Proc (NAACCR) p. E-79
 103. RX Hosp--DX/Stg/Pall, RX Summ--DX/Stg/Pall (NAACCR) p. E-79
- field: **RX Hosp--Hormone** (called Hormone Therapy -- At This Facility in MCR Manual)
 edits: 104. RX Hosp--Hormone (NAACCR) p. E-79
 105. RX Hosp--Hormone, RX Summ--Hormone (COC) p. E-80
- field: **RX Hosp--Other** (called Other Cancer-Directed Therapy--At This Facility in MCR Manual)
 edits: 106. RX Hosp--Other (NAACCR) p. E-80
 107. RX Hosp--Other, RX Summ--Other (COC) p. E-80
- field: **RX Hosp--Radiation** (called Radiation Therapy -- At This Facility in MCR Manual)
 edits: 108. RX Hosp--Radiation (NAACCR) p. E-80
 109. RX Hosp--Radiation, RX Summ--Radiation (COC) p. E-81
- field: **RX Hosp--Reg LN Removed** (called Number of Regional Lymph Nodes Removed--At This Facility in MCR Manual)
 edits: 110. RX Hosp--Reg LN Examined (NAACCR) p. E-81
 114. RX Hosp--Scope Reg LN Sur,RX Hosp--Reg LN Ex (COC p. E-82
- field: **RX Hosp--Scope Reg LN Sur** (called Scope of Regional Lymph Node Surgery--At This Facility in MCR Manual)
 edits: 112. RX Hosp--Scope Reg LN Sur (NAACCR) p. E-81
 111. RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC) p. E-81
 113. RX Hosp--Scope Reg LN Sur, Primary Site (COC) p. E-82
 114. RX Hosp--Scope Reg LN Sur,RX Hosp--Reg LN Ex (COC p. E-82
- field: **RX Hosp--Surg Oth Reg/Dis** (called Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes--At This Facility in MCR Manual)
 edits: 116. RX Hosp--Surg Oth Reg/Dis (NAACCR) p. E-83
 115. RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC) p. E-82
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- field: **RX Hosp--Surg Prim Site** (called Surgery of Primary Site -- At This Facility in MCR Manual)
 edits: 119. RX Hosp--Surg Prim Site (NAACCR) p. E-83
 118. RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC) p. E-83
 120. RX Hosp--Surg Prim Site, Primary Site (COC) p. E-84
- field: **RX Summ--BRM** (called Immunotherapy -- Summary in MCR Manual)
 edits: 121. RX Summ--BRM (COC) p. E-84
 99. RX Hosp--BRM, RX Summ--BRM (COC) p. E-78
 122. RX Summ--BRM, RX Date--BRM (COC) p. E-84
 123. RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS) p. E-84
- field: **RX Summ--Chemo** (called Chemotherapy -- Summary in MCR Manual)
 edits: 124. RX Summ--Chemo (COC) p. E-85
 101. RX Hosp--Chemo, RX Summ--Chemo (COC) p. E-79
 125. RX Summ--Chemo, RX Date--Chemo (COC) p. E-85
 126. RX Summ--Chemo, RX Text--Chemo (NAACR/MCR-CIMS) p. E-85

- field: **RX Summ--DX/Stg/Pall Proc** (called Diagnostic/Staging/Palliative Procedures--Summary in MCR Manual)
- edits: 127. RX Summ--DX/Stg/Pall Proc (COC) p. E-85
 103. RX Hosp--DX/Stg/Pall, RX Summ--DX/Stg/Pall (NAACCR) p. E-79
 128. RX Summ--DX/Stg/Pall, RX Date--DX/Stg/Pall Proc (NAACCR) p. E-86
- field: **RX Summ--Hormone** (called Hormone Therapy -- Summary in MCR Manual)
- edits: 129. RX Summ--Hormone (COC) p. E-86
 105. RX Hosp--Hormone, RX Summ--Hormone (COC) p. E-80
 130. RX Summ--Hormone, RX Date--Hormone (COC) p. E-86
 131. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS) p. E-86
- field: **RX Summ--Other** (called Other Cancer-Directed Therapy -- Summary in MCR Manual)
- edits: 132. RX Summ--Other (COC) p. E-87
 107. RX Hosp--Other, RX Summ--Other (COC) p. E-80
 133. RX Summ--Other, RX Date--Other (COC) p. E-87
 134. RX Summ--Other, RX Text--Other (NAA/MCR-CIMS) p. E-87
- field: **RX Summ--Radiation** (called Radiation Therapy -- Summary in MCR Manual)
- edits: 135. RX Summ--Radiation (COC) p. E-87
 109. RX Hosp--Radiation, RX Summ--Radiation (COC) p. E-81
 136. RX Summ--Radiation, RX Date--Radiation (COC) p. E-88
 162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
- field: **RX Summ--Reconstruct 1st** (called Reconstruction -- First Course in MCR Manual)
- edits: 137. RX Summ--Reconstruct 1st (NAACCR) p. E-88
 138. RX Summ--Reconstruct 1st, Primary Site (COC) p. E-88
- field: **RX Summ--Reg LN Examined** (called Number of Regional Lymph Nodes Removed--Summary in MCR Manual)
- edits: 139. RX Summ--Reg LN Examined (COC) p. E-88
 142. RX Summ--Scope Reg LN Sur, RX Summ--Reg LN Ex (NPCR) p. E-89
- field: **RX Summ--Scope Reg LN Sur** (called Scope of Regional Lymph Node Surgery--Summary in MCR Manual)
- edits: 140. RX Summ--Scope Reg LN Sur (COC) p. E-88
 111. RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur (COC) p. E-81
 141A. RX Summ--Scope Reg LN Sur, Primary Site (COC) p. E-89
 141B. RX Summ--Scope Reg LN Sur, Primary Site, ICDO3 (COC) p. E-89
 142. RX Summ--Scope Reg LN Sur, RX Summ--Reg LN Ex (NPCR) p. E-89
 162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
 163. Surgery, Reason No Surg (COC) p. E-101
 164A. Surgery, RX Date--Surgery (COC) p. E-101
 164B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-102
- field: **RX Summ--Surg Oth Reg/Dis** (called Surgery of Other Regional Sites, Distant Sites or Distant Lymph Nodes--Summary in MCR Manual)
- edits: 143. RX Summ--Surg Oth Reg/Dis (COC) p. E-89
 115. RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC) p. E-82
 144. RX Summ--Surg Oth Reg/Dis, Primary Site (COC) p. E-90
 162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
 163. Surgery, Reason No Surg (COC) p. E-101
 164A. Surgery, RX Date--Surgery (COC) p. E-101
 164B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-102

- field: **RX Summ--Surg Prim Site** (called Surgery of Primary Site--Summary in MCR Manual)
 edits: 145. RX Summ--Surg Prim Site (COC) p. E-90
 118. RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC) p. E-83
 146. RX Summ--Surg Prim Site, Diag Conf (SEER IF76) p. E-90
 147. RX Summ--Surg Prim Site, Primary Site (COC) p. E-90
 162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
 163. Surgery, Reason No Surg (COC) p. E-101
 164A. Surgery, RX Date--Surgery (COC) p. E-101
 164B. Surgery, RX Date--Surgery, ICDO3 (COC) p. E-102
- field: **RX Summ--Surg/Rad Seq** (called Radiation / Surgery Sequence in MCR Manual)
 edits: 148. RX Summ--Surg/Rad Seq (SEER RADSEQ) p. E-90
 162. Surgery, Rad, Surg/Rad Seq (COC) p. E-100
- field: **RX Text--BRM** (called Immunotherapy -- Narrative in MCR Manual)
 edit: 123. RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS) p. E-84
- field: **RX Text--Chemo** (called Chemotherapy -- Narrative in MCR Manual)
 edit: 126. RX Summ--Chemo, RX Text--Chemo (NAACR/MCR-CIMS) p. E-85
- field: **RX Text--Hormone** (called Hormone Therapy -- Narrative in MCR Manual)
 edit: 131. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS) p. E-86
- field: **RX Text--Other** (called Other Cancer-Directed Therapy -- Narrative in MCR Manual)
 edit: 134. RX Summ--Other, RX Text--Other (NAA/MCR-CIMS) p. E-87
- field: **RX Text--Radiation (Beam)** (called Radiation Therapy -- Narrative in MCR Manual)
 edits: none
- field: **RX Text--Surgery** (called Surgery -- Narrative in MCR Manual)
 edit: 97. RX Date--Surgery, RX Text--Surgery (NAA/MCR-CIMS) p. E-78
- field: **SEER Summary Stage 1977**
 edits: 154A. Summary Stage (NAACCR) p. E-92
 14A. Behavior, Summary Stage (NAACCR) p. E-41
 38. Hemato, Summ Stage, Class of Case (NAACCR) p. E-51
 39. Hemato, Summ Stage, Type of Report Srce (NAACCR) p. E-52
 50. Lymphoma, Primary Site, Summary Stage (NAACCR) p. E-57
 155B. Summary Stage, Date of Diagnosis (NAACCR) p. E-96
 161. Summary Stage, Histology (COC) p. E-96
 156B. Summary Stage, Regional Nodes Pos (NAACCR) p. E-97
 159B. Summary Stage, TNM M (NAACCR) p. E-98
 160B. Summary Stage, TNM N (NAACCR) p. E-99
 182. Unknown Site, Summary Stage (NAACCR) p. 109
- field: **SEER Summary Stage 2000**
 edits: 154B. Summary Stage 2000 (NAACCR) p. E-92
 14B. Behavior, Summary Stage 2000 (NAACCR) p. E-42
 155A. Summary Stage 2000, Date of Diagnosis (NAACCR) p. E-92
 156A. Summary Stage 2000, Regional Nodes Pos (NAACCR) p. E-93
 157. Summary Stage 2000, Site, Hist, Class (NAACCR) p. E-93
 158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR) p. E-94
 159A. Summary Stage 2000, TNM M (NAACCR) p. E-95
 160A. Summary Stage 2000, TNM N (NAACCR) p. E-96

field: **Sequence Number--Hospital**
edit: 149. Sequence Number--Hospital (COC) p. E-91

field: **Sex**
edits: 150. Sex (SEER SEX) p. E-91
151. Sex, Primary Site (SEER IF17) p. E-91

field: **Social Security Number**
edit: 152. Social Security Number (NAACCR) p. E-92

field: **Spanish/Hispanic Origin**
edit: 153. Spanish/Hispanic Origin (SEER SPANORIG) p. E-92

field: **Text--DX Proc--Lab Tests**
edits: none

field: **Text--DX Proc--Op**
edits: none

field: **Text--DX Proc--Path**
edits: none

field: **Text--DX Proc--PE**
edits: none

field: **Text--DX Proc--Scopes**
edits: none

field: **Text--DX Proc--X-Ray/Scan**
edits: none

field: **Text--Histology Title** (called Narrative Histology/Behavior/Grade in MCR Manual)
edit: 71. Primary Site, Histology Narratives check (MCR-CIMS) p. E-66

field: **Text--Primary Site Title** (called Narrative Primary Site in MCR Manual)
edit: 71. Primary Site, Histology Narratives check (MCR-CIMS) p. E-66

field: **Text--Remarks** (called Comments / Narrative Remarks in MCR Manual)
edits: none

field: **Text--Staging**
edits: none

field: **Text--Usual Industry** (called Usual Industry / Type of Business in MCR Manual)
edit: 7. Age at Diagnosis, Text--Usual Industry (NAACCR/MCR p. E-36)

field: **Text--Usual Occupation** (called Usual Occupation in MCR Manual)
edit: 8. Age at Diagnosis, Text--Usual Occupation (NAACCR/MCR p. E-37)

- field: **TNM Clin M** (called Clinical M in MCR Manual)
- edit: 165. TNM Clin M (COC) p. E-102
- 40A. Hematopoietic, TNM (NAACCR) p. E-52
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 51A. Lymphoma, TNM (NAACCR) p. E-57
 - 51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 - 159A. Summary Stage 2000, TNM M (NAACCR) p. E-95
 - 159B. Summary Stage, TNM M (NAACCR) p. E-98
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **TNM Clin N** (called Clinical N in MCR Manual)
- edit: 166. TNM Clin N (COC) p. E-103
- 40A. Hematopoietic, TNM (NAACCR) p. E-50
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 51A. Lymphoma, TNM (NAACCR) p. E-57
 - 51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 - 160A. Summary Stage 2000, TNM N (NAACCR) p. E-96
 - 160B. Summary Stage, TNM N (NAACCR) p. E-99
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **TNM Clin Stage Group** (called Clinical Stage Grouping in MCR Manual)
- edits: 167. TNM Clin Stage Group (COC) p. E-103
- 40A. Hematopoietic, TNM (NAACCR) p. E-52
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-73
 - 168. TNM Clin Stage Group, TNM Path Stage Group (COC) p. E-104
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **TNM Clin T** (called Clinical T in MCR Manual)
- edit: 169. TNM Clin T (COC) p. E-104
- 40A. Hematopoietic, TNM (NAACCR) p. E-52
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 51A. Lymphoma, TNM (NAACCR) p. E-57
 - 51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **TNM Edition Number**
- edit: 170. TNM Edition Number (COC) p. E-104

- field: **TNM Path M** (called Pathologic M in MCR Manual)
- edits: 171. TNM Path M (COC) p. E-105
- 40A. Hematopoietic, TNM (NAACCR) p. E-50
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 51A. Lymphoma, TNM (NAACCR) p. E-57
 - 51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 - 159A. Summary Stage 2000, TNM M (NAACCR) p. E-95
 - 159B. Summary Stage, TNM M (NAACCR) p. E-98
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **TNM Path N** (called Pathologic N in MCR Manual)
- edits: 172. TNM Path N (COC) p. E-105
- 40A. Hematopoietic, TNM (NAACCR) p. E-52
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 51A. Lymphoma, TNM (NAACCR) p. E-57
 - 51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 - 160A. Summary Stage 2000, TNM N (NAACCR) p. E-96
 - 160B. Summary Stage, TNM N (NAACCR) p. E-99
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **TNM Path Stage Group** (called Pathologic Stage Grouping in MCR Manual)
- edits: 173. TNM Path Stage Group (COC) p. E-106
- 40A. Hematopoietic, TNM (NAACCR) p. E-50
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 - 168. TNM Clin Stage Group, TNM Path Stage Group (COC) p. E-104
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **TNM Path T** (called Pathologic T in MCR Manual)
- edits: 174. TNM Path T (COC) p. E-106
- 40A. Hematopoietic, TNM (NAACCR) p. E-52
 - 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 - 51A. Lymphoma, TNM (NAACCR) p. E-57
 - 51B. Lymphoma, TNM, ICDO3 (NAACCR) p. E-58
 - 74A. Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR) p. E-71
 - 74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR) p. E-72
 - 175. TNM-Emptiness Check (MCR-CIMS) p. E-107
- field: **Tobacco History**
- edit: 176. Tobacco History (MCR-CIMS) p. E-107

field: **Type of Reporting Source**

edits: 180. Type of Reporting Source (SEER RPRTSRC) p. E-108
 14B. Behavior, Summary Stage 2000 (NAACCR) p. E-42
 19. Class of Case, Type of Reporting Source (NAACCR) p. E-43
 34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR) p. E-49
 34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR) p. E-49
 36A. EOD--Tumor Size, Primary Site (NAACCR) p. E-50
 36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR) p. E-51
 39. Hemato, Summ Stage, Type of Report Srce (NAACCR) p. E-52
 40A. Hematopoietic, TNM (NAACCR) p. E-52
 40B. Hematopoietic, TNM, ICDO3 (NAACCR) p. E-52
 158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR) p. E-94
 177. Type of Report Srce(DC/AO), Date of Dx (SEER IF02) p. E-107
 178. Type of Report Srce(DC/AO), Diag Conf (SEER IF05) p. E-108
 179. Type of Report Srce(DC/AO), Vit Stat (COC) p. E-108

field: **Vendor Name** (called Vendor Name / Version Number in MCR Manual)
 edits: none

field: **Vital Status**

edits: 184. Vital Status (COC) p. E-110
 20. Class, Date Diag, Date Last Cont, Vit Stat (COC) p. E-44
 67. Place of Death, Vital Status (NAACCR) p. E-64
 179. Type of Report Srce(DC/AO), Vit Stat (COC) p. E-108

field: **Year First Seen This CA** (called Year First Seen for This Primary in MCR Manual)

edits: 185. Year First Seen This CA (COC) p. E-110
 114. RX Hosp--Scope Reg LN Sur,RX Hosp--Reg LN Ex (COC) p. E-82
 141A. RX Summ--Scope Reg LN Sur, Primary Site (COC) p. E-89
 141B. RX Summ--Scope Reg LN Sur, Primary Site, ICDO3(COC) p. E-89
 186. Year First Seen This CA, Date of DX (NAACCR) p. E-110

Descriptions of MCR Automated Edits

1. **Abstracted By (NAACCR)**

field involved: Abstracted By (3 characters long)

This edit is a simple character check.

The field cannot contain symbols or leading spaces.

The field cannot be empty.

We ordinarily expect this field to contain only uppercase letters, but this edit will also allow lowercase letters, numbers and embedded spaces. We would not normally expect to alter what you have sent us in this field, but we run this edit so that we can detect problems with the field (such as being sent in empty).

2. **Addr at DX--City (NAACCR)**

field involved: Addr at DX--City (20 characters long)

This is a simple character check.

The field may only contain letters and embedded spaces.

The field cannot contain symbols or leading spaces.

The field cannot be empty, even for non-analytic cases. (Please remember to enter “Unknown” when necessary.)

3A. **Addr at DX--Postal Code (NAACCR)**

3B **Addr at DX--Postal Code (NAACCR/MCR-CIMS)**

field involved: Addr at DX--Postal Code (9 characters long)

The standard NAACCR edit (3A.) is a simple character check.

The field may only contain letters and numbers. (Allowing letters makes it possible to include the Canadian Postal Codes, for example.)

The field cannot contain symbols or spaces.

The field cannot be empty.

The MCR-modified version of the edit (3B.) is run only in the Scan Edit Set. It complains when the postal code starts with five 9's. The unknown code is valid, but we have had a problem in the past with files being sent in with a *large* percentage of unknown postal codes. We use this edit to identify files with too many unknown postal codes that may have to be rejected.

4. **Addr at DX--State (NAACCR)**

field involved: Addr at DX--State (2 letters long)

This is a validity check.

The field can only contain a valid 2-letter code for U.S. states, Canadian provinces, or the special codes **XX**, **YY** or **ZZ**. Valid codes are on page 58 in the MCR Manual and pages 57-58 in the ROADS Manual. The edit uses a look-up table of valid codes.

The field cannot be empty.

5. **Address at dx--No & Street (MCR-CIMS)**

field involved: Addr at DX--No & Street (25 characters long)

This is a simple blank check.

The field can contain any type of character -- letters, numbers, symbols, a leading space, and embedded spaces.

The field cannot be empty.

The MCR modified a standard version of this edit to allow symbols that may make the address easier for us to interpret. Having elements included in this field like “1/2”, “Apt #4” or “Bldg D-2” provides us with the detailed information necessary to locate a residence as specifically as possible.

6. **Age at Diagnosis (SEER AGEDX)**

field involved: Age at Diagnosis (3 digits long)

This is a validity check.

The field can only contain a 3-digit number from **000** through **120**, or the special code **999**.

The field cannot contain letters, symbols or spaces.

The field cannot be empty.

(The COC version of this edit allows the field to be empty because the field is not required by the COC.)

7. **Age at Diagnosis, Text--Usual Industry (NAACCR/MCR)**

fields involved: Age at Diagnosis
Birth Date
Class of Case
Date of Diagnosis
Text--Usual Industry

This edit runs only in the MCR Scan Edit Set. This edit checks that the industry narrative is filled for any patient old enough to have worked (fourteen years old). Please fill in the text “unknown” if you have checked the medical record and could find no usual type of industry. Fill in “student” if a teen has no job or you can’t find one in the record.

If the patient’s age > **013** then the narrative usual industry cannot be empty.

The edit skips whenever the year of diagnosis is before **1996**. If the patient’s age is empty for a case record, the edit uses Birth Date and Date of Diagnosis to calculate it so that it need not skip.

Because the MCR does not require narratives to be filled for most nonanalytic cases, the edit skips when Class of Case=**3, 4, 6, 9**.

8. **Age at Diagnosis, Text--Usual Occupation (NAACCR/MCR)**

fields involved: Age at Diagnosis
 Birth Date
 Class of Case
 Date of Diagnosis
 Text--Usual Occupation

This is a companion to the preceding edit and it also runs only in the Scan Edit Set. This edit checks that the occupation narrative is filled for any patient old enough to have worked (fourteen). Please fill in the text “unknown” if you have checked the medical record and could find no usual occupation. Fill in “student” if a teen has no job or you can’t find one in the record.

If the patient’s age > **013** then the narrative usual occupation cannot be empty.

The edit skips whenever the year of diagnosis is before **1996**. If the patient’s age is empty for a case record, the edit uses Birth Date and Date of Diagnosis to calculate it so that it need not skip.

Because the MCR does not require narratives to be filled for most nonanalytic cases, the edit skips when Class of Case=**3, 4, 6, 9**.

9. **Age, Birth Date, Date of Diagnosis (NAACCR IF13)**

fields involved: Age at Diagnosis
 Birth Date
 Date of Diagnosis

This edit checks that these three fields are in agreement.

This edit is skipped for a case record if any of the three fields has failed its validity check.

If both dates are known (that is, no unknown years or months or days), then the edit uses all of these elements (even down to the days) to calculate an age; then it checks that the coded age is the same.

If either date is partially or completely unknown, then just the known parts are used to calculate the age.

The patient’s age can only be coded as completely unknown (**999**) if the birth year or diagnosis year (or both) is coded as unknown (**9999**). (Remember that we would prefer an estimated age to a complete unknown; also, an unknown diagnosis year is useless to the MCR because we cannot even determine if that case is reportable to us.)

10A. **Age, Primary Site, Morphology (NAACCR IF15)**

fields involved: Age at Diagnosis
 Behavior (92-00) ICD-O-2
 Histology (92-00) ICD-O-2
 Primary Site

This edit looks at the patient’s age and ICD-O-2 diagnosis. If the disease is unusual for someone of this age, the edit asks for a double-check of the data.

This edit is skipped for a case record if any of the validity checks on the involved fields has failed. It skips if the ICD-O-2 Behavior and Histology are empty.

The following combinations of age and diagnosis require review:

Age	Primary Site	Histologic Type	Behavior
under 15 years	cervix uteri (C530-C539)	any	<i>in situ</i> (2)
	placenta (C589)	choriocarcinoma (9100)	any
under 20 years	colon (C180-C189) trachea (C339) lung and bronchus (C340-C349)	any except carcinoid tumor (8240-8244)	any
	esophagus (C150-C159) small intestine (C170-C179) rectosigmoid (C199) rectum (C209) anus and anal canal (C210-C218) gallbladder (C239) other biliary tract (C240-C249) pancreas (C250-C259) pleura (C384) breast (C500-C509) corpus uteri (C540-C549) uterus, NOS (C559)	any	any
	cervix uteri (C530-C539)	any	malignant (3)
	any	multiple myeloma (9732) chronic lymphocytic leukemia (9823) chronic myeloid leukemia (9863, 9868) monocytic leukemia, NOS (9890)	malignant (3)
	penis (C609)	any	any
under 45 years	prostate (C619)	adenocarcinoma, NOS (8140)	any
over 5 years	eye (C690-C699)	retinoblastoma (9510-9512)	any
over 14 years	any	Wilms's tumor (8960)	any
over 45 years	placenta (C589)	choriocarcinoma (9100)	any

This edit has an over-ride ("Age/Site/Morph").

10B. Age, Primary Site, Morphology ICDO3 (NAACCR IF15)

fields involved: Age at Diagnosis
Behavior Code ICD-O-3
Histologic Type ICD-O-3
Primary Site

This is the ICD-O-3 version of the preceding edit

This edit is skipped for a case record if any of the validity checks on the involved fields has failed. It skips if the ICD-O-3 behavior and histology are empty.

The following combinations of age and diagnosis require review:

Age	Primary Site	Histologic Type	Behavior
under 15 years	cervix uteri (C530-C539)	any	<i>in situ</i> (2)
	placenta (C589)	choriocarcinoma (9100)	any
under 20 years	colon (C180-C189) trachea (C339) lung and bronchus (C340-C349)	any except carcinoid tumor (8240-8245)	any
	esophagus (C150-C159) small intestine (C170-C179) rectosigmoid (C199) rectum (C209) anus and anal canal (C210-C218) gallbladder (C239) other biliary tract (C240-C249) pancreas (C250-C259) pleura (C384) breast (C500-C509) corpus uteri (C540-C549) uterus, NOS (C559)	any	any
	cervix uteri (C530-C539)	any	malignant (3)
	any	multiple myeloma (9732) chronic lymphocytic leukemia (9823) chronic myeloid leukemia (9876, 9945) monocytic leukemia, NOS (9946)	malignant (3)
	penis (C609)	any	any
	prostate (C619)	adenocarcinoma, NOS (8140)	any
	eye (C690-C699)	retinoblastoma (9510-9514)	any
	any	Wilms tumor (8960)	any
over 45 years	placenta (C589)	choriocarcinoma (9100)	any

This edit has an over-ride (“Age/Site/Morph”).

11A. Behavior (COC)

field involved: Behavior (92-00) ICD-O-2 (1 digit long)

This is a simple validity check.

Valid codes are **0**, **1**, **2** and **3**.

The field cannot be empty.

12A. Behavior Code, Histologic Type (NAACCR/MCR-CIMS)

fields involved: Behavior (92-00) ICD-O-2
 Date of Diagnosis (year only)
 Histology (92-00) ICD-O-2
 Primary Site

The only morphologies with borderline/uncertain (/1) behaviors in ICD-O-2 that should appear in *most* central registry data systems are those that now appear in ICD-O-3 with an invasive (/3) behavior:

8931	endolymphatic stromal myosis	9980	refractory anemia
9393	papillary ependymoma	9981	refractory anemia without sideroblasts
9538	papillary meningioma	9982	refractory anemia with sideroblasts
9950	polycythemia vera	9983	refractory anemia with excess of blasts
9960	chronic myeloproliferative disease	9984	refractory anemia with excess of blasts in transformation
9961	myelosclerosis with myeloid metaplasia	9989	myelodysplastic syndrome
9962	idiopathic thrombocytopenia		

If the diagnosis year>2000 and the ICD-O-2 behavior=1 and the ICD-O-2 histologic type code is one of those listed above, the standard version of this edit passes; otherwise it fails.

Because the MCR collects brain/CNS cancers having benign and borderline behaviors, however, our data system has many other ICD-O-2 borderline morphologies than just those that have become invasive. The standard version of this edit would reject all of those borderline cases that are reportable to the MCR. Our modification of the edit does this: if ICD-O-2 behavior=1 and diagnosis year<2001 and ICD-O-2 histologic type is one of those above (except **9393** or **9538**, which may typically appear in the brain/CNS sites), the edit fails.

13A. Behavior ICDO2, Date of Diagnosis (NAACCR)

fields involved: Behavior (92-00) ICD-O-2
 Date of Diagnosis (year only)

This edit checks that the ICD-O-2 Behavior code is not empty for any diagnosis made before 2001.

If the year of diagnosis<2001 and the ICD-O-2 Behavior is empty, the edit fails.

11B. Behavior ICDO3 (COC)

field involved: Behavior Code ICD-O-3 (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3**; the field may also be empty (the edit that immediately follows checks that it is not empty for any case diagnosed in 2001 and thereafter).

13B. Behavior ICDO3, Date of Diagnosis (NAACCR)

fields involved: Behavior Code ICD-O-3
 Date of Diagnosis (year only)

This edit checks that the ICD-O-3 Behavior code is not empty for any diagnosis made after 2000.

If the year of diagnosis>2000 (but not **9999**) and the ICD-O-3 Behavior is empty, the edit fails.

12B. Behavior ICDO3, Histologic Type ICDO3 (NAACCR/MCR)

fields involved: Behavior Code ICD-O-3
 Date of Diagnosis (year only)
 Histologic Type ICD-O-3
 Primary Site

The only morphologies with borderline/uncertain (/1) behaviors in ICD-O-3 that should appear in *most* central registry data systems are those that appeared in ICD-O-2 with an invasive (/3) behavior:

- 8442** serous cystadenoma, borderline malignancy
- 8451** papillary cystadenoma, borderline malignancy
- 8462** serous papillary cystic tumor of borderline malignancy
- 8472** mucinous cystic tumor of borderline malignancy
- 8473** papillary mucinous cystadenoma, borderline malignancy

If the diagnosis year<**2001** and the ICD-O-3 behavior=**1** and the ICD-O-3 histologic type code is one of those listed above, the standard version of this edit passes; otherwise it fails.

Because the MCR collects brain/CNS cancers having benign and borderline behaviors, however, our data system has many other ICD-O-3 borderline morphologies than just those that have become invasive. The standard version of this edit would reject all of those borderline cases that are reportable to the MCR. Our modification does this: if the ICD-O-3 behavior=**1** and diagnosis year>**2000** and ICD-O-3 histologic type is one of those above, the edit fails.

Note that pilocytic astrocytomas (**9421**) also appear in ICD-O-2 with /**3** and in ICD-O-3 with /**1**, but it is the practice of most North American registries to make the ICD-O-3 behavior /**3** for these cancers.

14A. Behavior, Summary Stage (NAACCR)

fields involved: Behavior (92-00) ICD-O-2
 SEER Summary Stage 1977

This edit checks for basic agreement between the ICD-O-2 behavior and the 1977 Summary Stage.

If the ICD-O-2 behavior is *in situ* (/2), then the Summary Stage 1977 must be **0** (*in situ*) or **9** (unknown, unstaged*).
 If the ICD-O-2 behavior is invasive (/3), then the Summary Stage 1977 can't be **0** (*in situ*).

This edit skips for a case record if the Summary Stage 1977 is empty.

* This edit takes into account that a death certificate-only case may have an unknown Summary Stage by default, regardless of the diagnosis.

14B. Behavior, Summary Stage 2000 (NAACCR)

fields involved: Behavior Code ICD-O-3
 SEER Summary Stage 2000
 Type of Reporting Source

This is the ICD-O-3/Summary Stage 2000 version of the preceding edit. The edit checks for basic agreement between the ICD-O-3 behavior and the Summary Stage 2000.

If the ICD-O-3 behavior is *in situ* (/2), then the Summary Stage 2000 must be **0** (*in situ*). Invasive ICD-O-3 behavior is not checked here.

The edit skips if the Summary Stage 2000 is empty. It skips for death certificate-only cases (Type of Reporting Source=7).

15. Birth Date (NAACCR DATEEDIT)

field involved: Birth Date (8 digits long)

This is a validity check, but it's not simple.

Valid day codes are **01 - 31** and **99**. The edit is smart enough to know which months have no 31st's and which years have February 29th's.

Valid month codes are **01 - 12** and **99**.

Valid year codes are **9999** and any year between 150 years ago* and today.

The edit only allows sensible use of the unknown codes. If the year is unknown, then the entire date must be unknown. If the year is known but the month is unknown, then the day must also be unknown.

The edit checks year first, then month, and then day; and it stops checking as soon as it finds something wrong. For example, if the year is OK but both the day and month are badly coded (**77 77 1999**, for example), the edit will validate the year, then detect the bad month code, and then stop -- it will not bother to check the day, so you will only get an error message complaining about the bad month code. This does not mean that the edit thinks that a day of **77** is valid -- it just did not bother to check the day code because it found the month problem first.

No part of the field may be blank. No letters, symbols or spaces are accepted. If the month or day is coded **00**, then the month or day is considered to be "missing" entirely.

This edit produces a variety of error messages. Depending on what type of error the edit had detected when it stopped, you may see a message like "##### is an invalid date", "invalid as to year", "invalid as to month", "invalid as to day**", "missing the year", "missing the month", or "missing the day".

Invalid parts of the date are checked for first (year, then month, then day), and "missing" parts of the date are checked for after this (year, then month, then day). For example, if the year is valid but the month is **00** and the day is **33** (**00 33 1999**), the edit will detect the invalid day code first and complain about that; having stopped there, the edit will not get around to detecting the "missing" month code.

* even though the maximum age that can be coded is 120 years

** Actually, you will see the message "invalid as *today*" because this error message contains a typo.

16. **Birth Date, Date of Diagnosis (NAACCR IF47)**

fields involved: Birth Date
Date of Diagnosis

This edit compares the two dates to see if they make sense together. The two dates may be identical, but diagnosis date cannot be earlier than birth date.*

This edit is skipped if either field has failed its validity check. It also skips if either year is coded unknown (**9999**).

If one or both dates is partially unknown, the edit only compares the known parts of the two dates. For example, if the birth date is **99991944** and the diagnosis date is **03032000**, the edit will only compare the two years.

* Although cancer diagnoses are being made before birth, the edit will not allow this. If your data system allows you to store a diagnosis date that precedes the birth date, we must ask that the diagnosis date be changed to equal the eventual birth date when such cases are exported for the MCR; otherwise, please explain the situation in a narrative field.

17. **Birthplace (SEER POB)**

field involved: Birthplace (3 digits long)

This is a simple validity check. It uses a look-up table of valid codes.

Valid codes are in MCR Manual Appendix A (Appendix C codes in the ROADS Manual are somewhat out-of-date).

The field cannot be empty.

18. **Class of Case (COC)**

field involved: Class of Case (1 digit long)

This is a simple validity check.

Valid codes are **0 - 6, 8*** and **9**.

The field cannot be empty.

* Although Class 8 cases (death certificate-only cases) should not be reported *to* the MCR, we enter them onto our data system ourselves. When we do so, this edit allows that code onto our system. If a facility reports a case to us coded with a Class of **8**, our system will not detect anything unusual and will process that case like any other.

19. **Class of Case, Type of Reporting Source (NAACCR)**

fields involved: Class of Case
Type of Reporting Source

This edit checks for basic agreement between some Classes of Case and the Type of Reporting Source code.

If the Class indicates no diagnosis until an autopsy (**5**), then the Type of Reporting Source must indicate that the case information came from an autopsy (**6**); and vice versa (if Type of Reporting Source=**6** then Class=**5**).

If the Class indicates a death certificate-only case (**8**), then the Type of Reporting Source must indicate that the case information came from a death certificate (**7**); and vice versa.

The edit skips if either field is empty.

20. Class, Date Diag, Date Last Cont, Vit Stat (COC)

fields involved: Class of Case
 Date of Diagnosis (year only)
 Date of Last Contact (year only)
 Vital Status

If a case wasn't diagnosed until death (on autopsy or death certificate), then the patient must be dead and the diagnosis and last contact dates should be the same (the death date). The edit checks the 4 fields for this agreement (well, really only the years of diagnosis and last contact have to be the same for the edit to be happy).

If Class of Case=5 (autopsy) or Class=8 (death certificate only), then year of last contact=diagnosis year and Vital Status=0 (dead).

This edit produces a single error message saying that the 4 fields are in conflict. It does not specify, for example, if just the Vital Status code conflicts with the Class.

21. Date Case Completed (MCR-CIMS)

field involved: Date Case Completed (8 digits long)

This is a date validity check. See Edit #15 on page E-42 for a description of what a date validity check does.

Although you may not have to fill this field in on your data system (your system may fill the field in for you), we need to run a validity check on it to be sure that the field is being filled correctly. The edit runs only in our Scan Set.

The field cannot be empty.

22. Date Case Exported (MCR-CIMS)

field involved: Date Case Record Exported (8 digits long)

This is a date validity check. See Edit #15 on page E-42 for a description of what a date validity check does.

This edit runs only in the Scan Edit Set. Your data system should be filling this field with the date on which each case record was put onto a floppy diskette for us. MCR staff cannot change the values in this field from within our data system. If you receive reports of cases failing this edit, then your data system is not putting some valid date into this field.

The field cannot be empty.

23. Date of 1st Crs RX--COC (COC)

field involved: Date of 1st Crs RX--COC (8 digits long)

This is a treatment date validity check.

A *treatment* date validity check is similar to the date validity check Edit #15 on page E-42, but it allows the date to be zero-filled; that is, if the year is 0000, then the entire date must be zeroes; if *only* the month and/or day is 00, or if *only* the year is 0000, the edit will complain.

The field cannot be empty.

24. **Date of 1st Crs RX--COC, Date Last Contact (COC)**

involved fields: Date of 1st Crs RX--COC
Date of Last Contact

This is a date comparison edit. The last contact date can be identical to the starting date for first-course cancer-directed treatment, but the last contact date cannot precede the other date.

The edit is skipped for a case record if either date has failed its validity check.

If no first-course cancer-directed treatment was given (Date of 1st Crs RX--COC is coded **00000000**), then this edit is skipped for that case record.

If either year is coded unknown (**9999**), then the edit is skipped for that case record.

If either date is partially unknown (or both), then the edit only compares the known parts of the two dates.

Note that this edit is not checking Date of Last Contact against the *latest* starting treatment date that may be recorded, but rather against the *earliest* starting treatment date.

25. **Date of 1st Crs RX--COC, Date of DX (COC)**

fields involved: Date of 1st Crs RX--COC
Date of Diagnosis

This is a date comparison edit. The diagnosis date can be identical to the treatment starting date, but treatment cannot start before diagnosis.

If either date is empty, the edit is skipped for that case record.

If no first-course cancer-directed treatment was given (Date of 1st Crs RX--COC is coded **00000000**), then this edit is skipped for that case record.

If either year is coded unknown (**9999**), then the edit is skipped for that case record.

If either date is partially unknown (or both), then the edit only compares the known parts of the two dates.

26. **Date of 1st Crs RX--COC, Dates of RX (NAACCR)**

fields involved: Date of 1st Crs RX--COC
 RX Date--BRM
 RX Date--Chemo
 RX Date--Hormone
 RX Date--Other
 RX Date--Radiation
 RX Date--Surgery

This edit compares the starting treatment date with the start dates of each cancer-directed treatment modality. The *overall* starting date cannot be later than any of the individual start dates.

The edit skips for a case record if any of the dates involved is empty. It skips if all of the treatment modality dates are zero-filled (because, if no treatment was done, the Date of 1st Crs RX may be zero-filled or may be some real date on which it was decided to do no treatment).

If any of the treatment modality dates is not zero-filled, then the Date of 1st Crs RX can't be zero-filled.

The Date of 1st Crs RX must be the earliest non-zero-filled treatment modality start date.

This edit is being modified by NAACCR to allow the possibility that you know a certain modality was the first treatment given, yet you cannot specify its date. For example, you may know that the patient had surgery first at another facility and then your facility later gave radiation; if you cannot estimate the surgery date, you will 9-fill its starting date field and therefore must 9-fill the overall treatment starting date. The MCR will not be adopting this modification at this time.

27. **Date of Adm/1st Contact (NAACCR DATEEDIT)**

field involved: Date of First Contact (8 digits long)

This is a date validity check. See Edit #15 on page E-42 for a description of what a date validity check does.

28. **Date of Diagnosis (NAACCR DATEEDIT)**

field involved: Date of Diagnosis (8 digits long)

This is a date validity check. See Edit #15 on page E-42 for a description of what a date validity check does.

29. **Date of Last Contact (NAACCR DATEEDIT)**

field involved: Date of Last Contact (8 digits long)

This is a date validity check. See Edit #15 on page E-42 for a description of what a date validity check does.

30. **Date of Last Contact, Date of Diag. (NAACCR IF19)**

fields involved: Date of Diagnosis
Date of Last Contact

This is a date comparison edit. The two dates may be identical, but the last contact cannot precede the diagnosis.

If either date has failed its validity check, this edit is skipped for that case record.

If either year (or both) is unknown (**9999**), the edit is skipped for that case record.

If either date (or both) is partially unknown, then only the known parts of the dates are compared.

31. **Diagnostic Confirmation (SEER DXCONF)**

field involved: Diagnostic Confirmation (1 digit long)

This is a simple validity check.

Valid codes are **1, 2, 4 - 9**.

The field cannot be empty.

32A. **Diagnostic Confirmation, Behavior Code (SEER IF31)**

fields involved: Behavior (92-00) ICD-O-2
Diagnostic Confirmation

This edit checks that cases coded with an *in situ* ICD-O-2 behavior have been microscopically confirmed.

The edit is skipped for a case record if either field has failed its validity check or if the ICD-O-2 behavior is empty.

If the ICD-O-2 behavior=**2** and the Diagnostic Confirmation is *not* **1, 2 or 4**, the edit asks that the data be reviewed.

There is an over-ride for this edit (the “Histology” over-ride flag must be set to 2 or 3).

The edit text offers this advice on cases questioned by the edit:

“The distinction between *in situ* and invasive is very important to a registry, since prognosis is so different, and *in situ* cases are usually excluded from incidence rate calculations. Since the determination that a neoplasm has not invaded surrounding tissue, i.e., is not *in situ*, is made via the microscope, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case non-invasive or *in situ* without microscopic evidence. Check carefully for any cytologic or histologic evidence that may have been missed in coding. Correction of errors may require inspection of the abstracted text.... Review of the original medical record may also be required. If upon review all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Set the Over-ride--Histology field to 2 (or 3, if the flag is also being set for the Morphology--Type&Behavior (SEER MORPH) edit).”

Note that staging codes are not checked by this edit. The edit uses only the ICD-O-2 behavior to determine if a case has been categorized as *in situ*.

32B. Diagnostic Confirmation, Behavior ICD03 (SEER IF31)

fields involved: Behavior Code ICD-O-3
Diagnostic Confirmation

This is the ICD-O-3 version of the preceding edit. The edit checks that cases coded with an *in situ* ICD-O-3 behavior have been microscopically confirmed.

If the ICD-O-3 behavior=2 and the Diagnostic Confirmation is *not* 1, 2 or 4, the edit asks that the data be reviewed.

There is an over-ride for this edit (the “Histology” over-ride flag must be set to 2 or 3).

The edit text offers the same advice for passing this edit as in the preceding edit.

33A. Diagnostic Confirmation, Histologic Typ(SEER IF48)

fields involved: Diagnostic Confirmation
Histology (92-00) ICD-O-2

The edit checks that diagnoses of lymphomas, leukemias, other lymphoreticular neoplasms, plasma cell tumors, mast cell tumors, and immunoproliferative diseases have been adequately confirmed.

If a lymphoma has been diagnosed by direct visualization (Diagnostic Confirmation = 6) or clinically (Diagnostic Confirmation = 8), the edit asks for review of the data.

If a leukemia (or other high-coded histology) has been diagnosed by direct visualization, the edit questions the data. Remember that positive hematologic findings and bone marrow specimens are considered histologic confirmation for leukemias (Diagnostic Confirmation = 1).

The edit requires review of the following code combinations:

Histology ICD-O-2 = 9590 - 9717	and	Diagnostic Confirmation = 6 or 8
Histology ICD-O-2 = 9720 - 9941	and	Diagnostic Confirmation = 6

The edit is skipped for a case record if either field has failed its validity check or if the ICD-O-2 histology is empty.

There is an over-ride for this edit (“Leuk, Lymphoma”).

33B. Diagnostic Confirmation, Histology ICD03(SEER IF48)

fields involved: Diagnostic Confirmation
Histologic Type ICD-O-3

This is the ICD-O-3 version of the preceding edit. It works exactly the same way. Lymphomas are defined with ICD-O-3 code range 9590 - 9729, and leukemias and the other high-coded histologies are defined by 9731 - 9948.

The edit is skipped for a case record if either field has failed its validity check or if the ICD-O-3 histology is empty.

There is an over-ride for this edit (“Leuk, Lymphoma”).

34A. EOD--Reg Nodes Ex,Reg Nodes Pos, Prim Site (NAACCR)

fields involved: Behavior (92-00) ICD-O-2
 Date of Diagnosis (year only)
 Histology (92-00) ICD-O-2
 Primary Site
 Regional Nodes Examined
 Regional Nodes Positive
 Type of Reporting Source

This edit checks that Regional Nodes Examined and Positive make sense together. It also checks that these two fields are coded correctly for certain diagnoses and cases. It produces a variety of error messages.

The edit skips if the ICD-O-2 Histology, Regional Nodes Examined or Regional Nodes Positive is empty. It skips for diagnoses made before **1998** and for any case record without an ICD-O-2 *in situ* (/2) or invasive (/3) behavior.

If Regional Nodes Examined=**00** (none examined), then Regional Nodes Positive=**98** (none examined).

If Regional Nodes Examined=**01 - 89** (specified number examined), then Regional Nodes Positive≤Regional Nodes Examined or Nodes Positive=**97** or **99** (an uncertain number positive, or you don't know if any were positive).

If Regional Nodes Examined=**90** (90+ examined), then Regional Nodes Positive=**00 - 97, 99** (none or any number positive is OK; you don't know if any were positive is also OK).

If Regional Nodes Examined=**95** (aspiration), then Regional Nodes Positive=**00, 97** or **99** (none were positive, an unknown number were positive, or you don't know if any nodes examined were positive).

If Regional Nodes Examined=**96-98** (uncertain number examined), then Regional Nodes Positive=**00 - 97, 99** (none or any number positive is OK; you don't know if any were positive is also OK).

If Regional Nodes Examined=**99** then Regional Nodes Positive=**99**.

Regional Nodes Examined and Regional Nodes Positive must both be coded **99** for these cases:

- death certificate-only cases (Type of Reporting Source=**7**);
- ICD-O-2 hematopoietic diseases (**9720 - 9989**);
- ICD-O-2 lymphomas (**9590 - 9698, 9702 - 9717**);
- brain and other CNS primaries (**C700-C709, C710-C719, C720-C729**) except Kaposi's sarcomas (**9140**);
- other/ill-defined sites (**C420-C424, C760-C768, C770-C779, C809**) except Kaposi's sarcomas (**9140**).

For all other cases, if *in situ* (ICD-O-2 behavior=**2**), Regional Nodes Positive must indicate that no nodes were positive (**00** or **98**) and Regional Nodes Examined <**99**.

34B. EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR)

fields involved: Behavior Code ICD-O-3
 Date of Diagnosis (year only)
 Histologic Type ICD-O-3
 Primary Site
 Regional Nodes Examined
 Regional Nodes Positive
 Type of Reporting Source

This is the ICD-O-3 version of the preceding edit. It skips when the diagnosis year<**1998**, ICD-O-3 Behavior<**1-3**, or the ICD-O-3 histology or nodes examined or nodes positive is empty.

The edit performs the same checks as the ICD-O-2 version. The ICD-O-3 diagnoses that require Regional Nodes Examined and Regional Nodes Positive to be **99** are the same as in the preceding edit, except as follows:

hematopoietic diseases (**9731-9732, 9740-9758, 9760-9989**) and lymphomas (**9590-9699, 9702-9729**).

35. **EOD--Tumor Size (COC)**

field involved: EOD--Tumor Size (3 digits long)

This edit is a simple character check.

The field should contain 3 numbers.

The field cannot contain letters, symbols or spaces. It should not contain only 1 or 2 digits.

The field cannot be empty.

36A. **EOD--Tumor Size, Primary Site (NAACCR)**

fields involved: Behavior (92-00) ICD-O-2
 Date of Diagnosis (year only)
 EOD--Tumor Size
 Histology (92-00) ICD-O-2
 Primary Site
 Type of Reporting Source

There are some special valid tumor size codes for certain ICD-O-2 diagnoses. This edit checks that the tumor size is not an invalid code for these diagnoses.

The edit skips if the diagnosis year < 1998, the ICD-O-2 Behavior < 2 or 3, or the ICD-O-2 Histology or tumor size is empty.

For the following ICD-O-2 cases, valid tumor size codes are **000 - 990, 998, 999**:

esophagus primaries (**C150 - C159**);

familial/multiple polyposis of colon, rectosigmoid junction or rectum (**C180 - C209, 8200 - 8221**);

bronchus and lung primaries (**C340 - C349**).

For breast primaries (**C500 - C509**), valid tumor size codes are **000 - 990, 997 - 999**.

For mycosis fungoides (**9700**) or Sezary's disease (**9701**) of skin (**C440 - C449**), vulva (**C510 - 519**), penis (**C600 - C601, C608 - C609**), or scrotum (**C632**), valid tumor size codes are **000 - 003***, **999**.

For Kaposi's sarcoma (**9140**) and Hodgkin's disease and non-Hodgkin's lymphomas (**9590-9595, 9650-9698, 9702-9717**), valid tumor size codes are **001 - 002****, **999**.

For hematopoietic diseases (**9720, 9722, 9731-9732, 9740-9741, 9760-9768, 9800-9941, 9950-9989**) and death certificate-only cases (Type of Reporting Source=7), only code **999** is valid for tumor size.

For all other cases, valid tumor size codes are **000 - 990, 999**.

* SEER uses codes **000-003** to indicate peripheral blood involvement status for these cases; the MCR does not collect this information, so we do not want codes 000-003 for these cases. Rather than modify this edit to disallow these codes, we check our data system for them periodically and change them to **999**.

** SEER uses codes 001 and 002 to indicate HIV status for these cases; the MCR does not collect such information, so we do not want codes 001 and 002 for these cases. Rather than modify this edit to disallow these codes, we check our data system for them periodically and change them to **999**.

36B. EOD--Tumor Size, Primary Site, ICDO3 (NAACCR)

fields involved: Behavior Code ICD-O-3
 Date of Diagnosis (year only)
 EOD--Tumor Size
 Histologic Type ICD-O-3
 Primary Site
 Type of Reporting Source

This is the ICD-O-3 version of the preceding edit.

The edit skips if diagnosis year<1998, ICD-O-3 behavior<>1-3, or the ICD-O-3 histology or tumor size is empty.

For the following ICD-O-3 cases, valid tumor size codes are **000 - 990, 998, 999**:

esophagus primaries (**C150 - C159**);
 familial/multiple polyposis of colon, rectosigmoid junction or rectum (**C180 - C209, 8200 - 8221**);
 bronchus and lung primaries (**C340 - C349**).

For breast primaries (**C500 - C509**), valid tumor size codes are **000 - 990, 997 - 999**.

For mycosis fungoides (**9700**) or Sezary syndrome (**9701**) of skin (**C440 - C449**), vulva (**C510 - 519**), penis (**C600 - C601, C608 - C609**), or scrotum (**C632**), valid tumor size codes are **000 - 003*, 999**.

For Kaposi sarcoma (**9140**) and Hodgkin and non-Hodgkin lymphomas (**9590-9699, 9702-9729**), valid tumor size codes are **001 - 002**, 999**.

For hematopoietic diseases (**9731-9734, 9750-9752, 9760-9989**) and death certificate-only cases (Type of Reporting Source=7), only code **999** is valid for tumor size.

For all other cases, valid tumor size codes are **000 - 990, 999**.

* SEER uses codes **000-003** to indicate peripheral blood involvement status for these cases; the MCR does not collect this information, so we do not want codes 000-003 for these cases. Rather than modify this edit to disallow these codes, we check our data system for them periodically and change them to **999**.

** SEER uses codes 001 and 002 to indicate HIV status for these cases; the MCR does not collect such information, so we do not want codes 001 and 002 for these cases. Rather than modify this edit to disallow these codes, we check our data system for them periodically and change them to **999**.

37. Grade (COC)

field involved: Grade (1 digit long)

This is a simple validity check.

Valid codes are **1 - 9** (any single digit).

The field cannot be empty.

38. Hemato, Summ Stage, Class of Case (NAACCR)

fields involved: Class of Case
 Histology (92-00) ICD-O-2
 SEER Summary Stage 1977

This edit checks that Summary Stage 1977 = **7** (systemic disease) for ICD-O-2 hematopoietic and reticuloendothelial neoplasms (**9720, 9722-9723, 9732, 9740-9741, 9760-9989**).

The edit skips if Summary Stage 1977 is empty. It also skips for death certificate-only cases (Class of Case=8).

39. **Hemato, Summ Stage, Type of Report Srce (NAACCR)**

fields involved: Histology (92-00) ICD-O-2
SEER Summary Stage 1977
Type of Reporting Source

This is the same as the preceding edit, but it uses Type of Reporting Source=7 to identify the death certificate cases.

40A. **Hematopoietic, TNM (NAACCR)**

fields involved: Class of Case
Date of Diagnosis (year only)
Histology (92-00) ICD-O-2
TNM Clin T
TNM Clin N
TNM Clin M
TNM Clin Stage Group
TNM Path T
TNM Path N
TNM Path M
TNM Path Stage Group
Type of Reporting Source

This edit checks that the TNM fields are coded correctly for certain ICD-O-2 cases.

Hematopoietic and reticuloendothelial neoplasms (ICD-O-2 histologies **9720, 9722-9723, 9731-9732, 9740-9741, 9760-9989**) have no AJCC staging schemes, so all of the TNM fields above must be coded **88**.

The edit skips when the diagnosis year < **1996**. It also skips if all of the TNM fields above are empty. It also skips for death certificate-only cases (Class of Case=**8** or Type of Reporting Source=**7**).

40B. **Hematopoietic, TNM, ICDO3 (NAACCR)**

fields involved: Class of Case
Date of Diagnosis (year only)
Histologic Type ICD-O-3
TNM Clin T
TNM Clin N
TNM Clin M
TNM Clin Stage Group
TNM Path T
TNM Path N
TNM Path M
TNM Path Stage Group
Type of Reporting Source

This is the ICD-O-3 version of the preceding edit. It does exactly what the preceding edit does, but it defines the diagnoses using ICD-O-3 histologies: **9731 - 9989**.

41A. Histologic Type (COC)

field involved: Histology (92-00) ICD-O-2 (4 digits)

This is a very simple validity check (just a code range check, really).

The edit checks that the ICD-O-2 histology code is within the range **8000 - 9989** or is empty (as it could be for diagnoses made after 2000).

41B. Histologic Type ICDO3 (COC)

field involved: Histologic Type ICD-O-3 (4 digits)

This is a very simple validity check. It's the ICD-O-3 version of the preceding edit.

The edit checks that the ICD-O-3 histology code is within the range **8000 - 9989** or is empty (as it could be for diagnoses made before 2001).

42A. Histology ICDO2, Date of Diagnosis (NAACCR)

fields involved: Date of Diagnosis (year only)
Histology (92-00) ICD-O-2

This is a blank check. It checks that the ICD-O-2 histology is not empty for diagnosis years <**2001**.

The edit skips if Date of Diagnosis fails its validity check.

43. Histology ICDO2, Histology ICDO3 (NAACCR)

fields involved: Histologic Type ICD-O-3
Histology (92-00) ICD-O-2

This is a double blank check. If both the ICD-O-2 and ICD-O-3 histology fields are empty, the edit fails.

42B. Histology ICDO3, Date of Diagnosis (NAACCR)

fields involved: Date of Diagnosis (year only)
Histologic Type ICD-O-3

This is a blank check, checking that the ICD-O-3 histology is not empty for diagnosis years >**2000** (except unknown year code **9999**).

The edit skips if Date of Diagnosis fails its validity check.

44. ICD-O-3 Conversion Flag (NAACCR)

field involved: ICD-O-3 Conversion Flag (1 digit)

This is a simple validity check.

The ICD-O-3 Conversion Flag must be a valid code **0 - 4** (codes **2** and **4** do not really apply, but they may be used).

The field may also be empty.

45. **Invalid City/Town Name (MCR-CIMS)**

field involved: Addr at DX--City (20 characters long)

This edit is run only when a case record in the MCR's data system is submitted to the system's "master database" by one of our staff. The edit is not in our Scan Edit Set and should not be of concern to our reporting facilities.

This edit prevents non-Massachusetts residents' cases from getting onto our "master database". It also prevents misspellings of town names and non-standard spellings. (Mass. city/town names are standardized during upload to MCR-CIMS.) The edit compares the reported city/town name with a look-up table of Massachusetts city/town names that we consider to be valid.

46. **Invalid Zipcode (MCR-CIMS)**

field involved: Addr at DX--Postal Code (9 characters long)

This edit is run only when a case record in the MCR's data system is submitted to the system's "master database" by one of our staff. The edit is not in our Scan Edit Set and should not be of concern to our reporting facilities.

This edit prevents non-Massachusetts residents' cases from getting onto our "master database". The edit compares the reported Postal Code with a look-up table of Massachusetts ZIP Codes that we consider to be valid.

47. **Laterality (SEER LATERAL)**

field involved: Laterality (1 digit long)

This is a simple validity check.

Valid codes are **0 - 4** and **9**.

The field cannot be empty.

48. **Laterality, Primary Site (NAACCR IF24)**

fields involved: Laterality
Primary Site

The edit checks that the laterality is *not* coded “not paired” for purely paired primary sites. That is, for paired sites, the Laterality code cannot be **0**.

The edit is skipped for a case record if either field has failed its validity check.

The primary sites that are considered “paired” for this edit follow:

C079	parotid gland	C471	peripheral nerves & autonomic nervous system, upper limb, shoulder
C080	submandibular gland	C472	peripheral nerves & autonomic nervous system, lower limb, hip
C081	sublingual gland	C491	connective, subcutaneous & other soft tissues, upper limb, shoulder
C090	tonsillar fossa	C492	connective, subcutaneous & other soft tissues, lower limb, hip
C091	tonsillar pillar	C50_	breast
C098	tonsil, overlapping	C569	ovary
C099	tonsil, NOS	C570	fallopian tube
C301	middle ear	C62_	testis
C310	maxillary sinus	C630	epididymis
C312	frontal sinus	C631	spermatic cord
C341	lung, upper lobe	C649	kidney, NOS
C342	lung, middle lobe*	C659	renal pelvis
C343	lung, lower lobe	C669	ureter
C348	lung, overlapping	C69_	eye & adnexa
C349	lung, NOS	C74_	adrenal gland
C384	pleura, NOS	C754	carotid body
C400	long bones of upper limb, scapula, joints		
C401	short bones of upper limb, joints		
C402	long bones of lower limb, joints		
C403	short bones of lower limb, joints		
C441	skin, eyelid		
C442	skin, external ear		
C443	skin, other and unspecified parts of face		
C445	skin, trunk		
C446	skin, upper limb, shoulder		
C447	skin, lower limb, hip		

Site codes which may or may not be paired, depending on the exact part of the site where the tumor began, are not checked by this edit because *any* valid laterality code may be appropriate for those site codes. For example, if the primary site is the carina (**C340**), the site is not paired and laterality should be coded **0**; but if the primary site is the main bronchus (also coded **C340**), the site is paired and laterality may be any valid code except **0**.

The edit ignores all purely unpaired primary sites. That is, if the site is coded **C169** for stomach and the laterality is coded **1** for “right side origin”, this incorrect combination is not checked by the edit at all.

* Although a middle lung lobe is found on the right side only, this is considered a paired site by this edit.

49A. **Laterality, Primary Site, Morph ICDO3 (NAACCR IF42)**

fields involved: Behavior Code ICD-O-3
 Date of Diagnosis (year only)
 Histologic Type ICD-O-3
 Laterality
 Primary Site

This edit checks that *in situ* (ICD-O-3 Behavior = **2**) lesions in purely paired primary sites are specified as originating in one side only (Laterality = **1 - 3**).

The edit skips if the ICD-O-3 histology is empty. It skips if any of the involved fields has failed its validity check. It skips for ICD-O-3 lymphomas and leukemias (any histology \geq **9590**). It skips for Kaposi sarcoma (**9140**), mycosis fungoides (**9700**), and Sezary syndrome (**9701**) diagnosed after 1987.

The edit asks for the data to be reviewed for the following code combinations:

ICD-O-2 behavior = 2	and	Laterality \neq 1, 2 or 3	and	Primary Site below:
C079 parotid gland				C446 skin, upper limb, shoulder
C080 submandibular gland				C447 skin, lower limb, hip
C081 sublingual gland				C471 peripheral nerves & autonomic nervous system, upper limb, shoulder
C090 tonsillar fossa				C472 peripheral nerves & autonomic nervous system, lower limb, hip
C091 tonsillar pillar				C491 connective, subcutaneous & other soft tissues, upper limb, shoulder
C098 tonsil, overlapping				C492 connective, subcutaneous & other soft tissues, lower limb, hip
C099 tonsil, NOS				C50_ breast
C301 middle ear				C569 ovary
C310 maxillary sinus				C570 fallopian
C312 frontal sinus				C62_ testis
C341 lung, upper lobe				C630 epididymis
C342 lung, middle lobe*				C631 spermatic cord
C343 lung, lower lobe				C649 kidney, NOS
C348 lung, overlapping				C659 renal pelvis
C349 lung, NOS				C669 ureter
C384 pleura, NOS				C69_ eye & adnexa
C400 long bones of upper limb, scapula, joints				C74_ adrenal gland
C401 short bones of upper limb, joints				C754 carotid body
C402 long bones of lower limb, joints				
C403 short bones of lower limb, joints				
C441 skin, eyelid				
C442 skin, external ear				

Site codes which may or may not be paired, depending on the exact part of the site where the tumor began, are not checked by this edit. For example, a non-invasive lesion said to originate in the nostril (site **C300**) with a Laterality code of **4** or **9** would not be questioned by this edit because the same site code could be indicating origin in the unpaired nasal septum.

The edit ignores all purely unpaired primary sites. That is, an *in situ* lesion with site coded **C189** for left colon and laterality coded **4** for "side of origin is unknown but both sides are involved" would not be questioned by this edit.

Staging is not checked by this edit. Only the Behavior Code is used to determine if a case has been called *in situ*.

This edit has an over-ride ("Site/Lat/Morph").

* Although a middle lung lobe is found on the right side only, this is considered a paired site by this edit.

49B. **Laterality, Primary Site, Morphology (NAACCR IF42)**

fields involved: Behavior (92-00) ICD-O-2
 Date of Diagnosis (just the year)
 Histology (92-00) ICD-O-2
 Laterality
 Primary Site

This is the ICD-O-2 version of the preceding edit.

This edit is skipped for a case record if any of the involved fields has failed its validity check or if the ICD-O-2 Histology is empty.

The edit asks for the data to be reviewed for the same code combinations that appear in the preceding edit, but it is the ICD-O-2 Behavior that is being checked here.

The ICD-O-2 Histology and Date of Diagnosis are involved because lymphomas, leukemias, etc. (ICD-O-3 histology \geq **9590**) are not checked by this edit. The edit does not check Kaposi sarcomas (**9140**), mycosis fungoides (**9700**) or Sezary syndrome (**9701**) diagnosed in 1988 or afterward.

This edit has an over-ride ("Site/Lat/Morph").

50. **Lymphoma, Primary Site, Summary Stage (NAACCR)**

fields involved: Histology (92-00) ICD-O-2
 Primary Site
 SEER Summary Stage 1977

This edit checks that the Summary Stage 1977 code makes sense for ICD-O-2 nodal lymphomas.

If Primary Site=**C770-C779** (lymph nodes) and ICD-O-2 histology=**9590-9595, 9650-9698, 9702-9717**, then Summary Stage 1977 \in **3, 4** (regional nodes involved).

If Primary Site=**C778** (multiple node regions involved) and histology=as above, then Summary Stage 1977 \in **1** (localized).

The edit skips if the Summary Stage 1977 is empty.

51A. **Lymphoma, TNM (NAACCR)**

fields involved: Histology (92-00) ICD-O-2
 TNM Clin T
 TNM Clin N
 TNM Clin M
 TNM Path T
 TNM Path N
 TNM Path M

This edit checks that all of the TNM elements are coded **88** for ICD-O-2 lymphomas (**9590-9698, 9702-9717**) because the TNM elements do not apply to these cases.

The edit skips if the ICD-O-2 histology is empty. It also skips if all of the TNM elements are empty.

51B. Lymphoma, TNM, ICDO3 (NAACCR)

fields involved: Histologic Type ICD-O-3
 TNM Clin T
 TNM Clin N
 TNM Clin M
 TNM Path T
 TNM Path N
 TNM Path M

This is the ICD-O-3 version of the preceding edit. This edit checks that all of the TNM elements are coded **88** for ICD-O-3 lymphomas (**9590-9699, 9702-9729**) because the TNM elements do not apply to these cases.

The edit skips if the ICD-O-3 histology is empty. It also skips if all of the TNM elements are empty.

52. Marital Status at DX (SEER MARITAL)

field involved: Marital Status at DX (1 digit long)

This is a simple validity check.

Valid codes are **1 - 5** and **9**.

The field cannot be empty.

53. Marital Status at DX, Age at Diagnosis (SEER IF14)

fields involved: Age at Diagnosis
 Marital Status at DX

This edit checks that patients under 15 years of age are coded as being "never married". Even if a marital status is not specified in the medical record, assume that someone this young has never married and code Marital Status as **0** rather than **9**. Finding any Marital Status code other than **0** with an age under 15 makes us suspect that there may have been a typographical error in entering the patient's birth date, leading to an erroneous Age at Diagnosis.

The edit is skipped for a case record if either field has failed its validity check.

54. MCR-CIMS Master Db Edits

fields involved: Addr at DX--State
 Date of Diagnosis (year only)

This edit is run only when a case record in the MCR's data system is submitted to the system's "master database" by one of our staff. The edit is not in our Scan Edit Set and should not be of concern to our reporting facilities.

This edit prevents case records from being added to our data system's master database if they are not cases that we want stored there. Our master database is meant to contain only cases diagnosed in Massachusetts residents as of January 1, 1995. All other cases are stored in different areas on our data systems.

The edit fails for all cases with State not coded as **MA, ma, Ma** or **Am**. If the state was incorrectly coded as "MA" (for Maine, for example), the edit would assume that this was Mass. case. If Massachusetts was incorrectly coded (as "MS", for example), the edit would assume that this was a non-Mass. resident.

The edit fails for all diagnosis years less than **1995**.

55. MCR-CIMS (NOT REPORTABLE CASE)

fields involved: Behavior Code ICD-O-3 and Behavior (92-00) ICD-O-2
 Class of Case
 Date of Diagnosis (year only)
 Histologic Type ICD-O-3 and Histology (92-00) ICD-O-2
 Primary Site

This edit only runs when a case record in the MCR data system is submitted to our "master database" by our staff. The edit should not concern reporting facilities, unless we find that you are sending in many cases that are non-reportable to us.

The Class of Case code **6** became valid as of 1996. Any Class **6** case diagnosed before 1996 is not reportable to us.

The MCR stopped collecting certain diseases diagnosed as of January 1, 1998. This edit is supposed to prevent such cases diagnosed after 1997 from being stored on our data system's master database. (There are standard edits which stop other types of disease that are not reportable to the MCR, such as non-melanoma skin cancers.)

For diagnoses made in 1998 and afterward, the MCR stopped collect cases of *in situ* carcinoma of the cervix (CIS), cervical intraepithelial neoplasia (CIN), prostatic intraepithelial neoplasia (PIN), vaginal intraepithelial neoplasia (VAIN), and vulvar intraepithelial neoplasia (VIN). When the diagnosis year is 1998 or afterward, the following code combinations are used by the edit to identify these unwanted cases:

site = C51_ or C529	and	behavior = 2 or 3	and	histology = 8077
site = C53_	and	behavior = 2	and	histology = 8000-8110
site = C619	and	behavior = 2	(combination over-rideable)	

The last part of this edit has an over-ride because a valid *in situ* prostate case is possible. PIN does not have specific codes to represent its diagnosis (that is, it may be reported with different histologies). If a case is coded in this way, our staff must determine if the disease being reported is PIN or *in situ*.

56A. Morphology--Type&Behavior (SEER MORPH)

fields involved: Behavior (92-00) ICD-O-2
 Grade
 Histology (92-00) ICD-O-2 (4 digits long)

This edit serves as the validity check on histology, but it's a complex edit that does several other things. There are different error messages attached to the edit, and the error message(s) you may see is determined by exactly what went wrong. One specific check performed by the edit is over-rideable (Part 2c below), while all other checks are pass/fail.

1.) The edit first checks that the histologic type code is any 4 digits between **8000** and **9999**. Any other code generates the error message "Histologic Type not valid".

2.) The edit then checks that only a valid code between **8000** and **9999** has been entered for histologic type. What does the edit consider to be a "valid" code? The edit goes to a huge look-up bin of codes that represents the entire ICD-O-2 coding system for histologic type, behavior and grade. Note that this part of the edit is only examining the 4-digit histologic type code and its default behaviors as listed in ICD-O-2. It is not looking at the Behavior Code reported in the case record.

a.) Any code not listed at all in ICD-O-2 generates the "Histologic Type not valid" error message.

example: Code **8005** is invalid because it does not appear in ICD-O-2.

b.) Any code listed in ICD-O-2 with a default behavior code of **2** or **3** (or both) is considered valid by the edit.

example: Code **8000** (for neoplasm) is valid because it appears in the book followed by a behavior of **3**.

c.) The edit questions the validity of any code in ICD-O-2 that only appears with a default behavior of **0** or **1**. There is an over-ride to allow the code to pass the edit if the data are reviewed and found to be correct.

example: code **8040** (for tumorlet) generates the error message "Benign Histology - Please Review" because it only appears in ICD-O-2 with a "/1".

If our staff examines the case record and finds that this is a benign brain/CNS cancer being reported, we can use the over-ride to accept the code; or, if a histology usually considered to be benign or uncertain in behavior is being "elevated" to a non-invasive or invasive behavior, we can use the over-ride to accept the code.

3.) Next, the edit looks at the Grade code reported in the case record in combination with the histology type code reported.*

a.) T-cell, B-cell, Null cell and Natural Killer cell origins (Grade codes **5 - 8**) are only allowed with lymphomas, leukemias and related diseases (ICD-O-2 histologies **9590 - 9941**). The error message "Grade not valid" will be generated if this part of the edit fails. Note that the edit is limiting Grade codes **5 - 8** to this histology range but, conversely, lymphomas and leukemias are allowed to have any valid Grade code (**1 - 9**).

b.) Histologies having a specific degree of differentiation implicit in their ICD-O-2 definitions must be reported with the appropriate Grade code only. The following histologies are limited to their implied grades:

8020/34	undifferentiated carcinoma
8021/34	anaplastic carcinoma
8331/31	well differentiated follicular adenocarcinoma
8851/31	well differentiated liposarcoma
9062/34	anaplastic seminoma
9082/34	undifferentiated malignant teratoma
9083/32	intermediate type malignant teratoma
9401/34	anaplastic astrocytoma
9451/34	anaplastic oligodendroglioma
9511/31	differentiated retinoblastoma
9512/34	undifferentiated retinoblastoma

One of these histologies reported with a different Grade code generates the error message "Grade & Histology conflict".

c.) Lymphoma/leukemia Grade codes can describe the cell type in which the disease originated or the degree of differentiation of the involved cells. (If both the cell type origin and differentiation are known, the cell type code has priority.) Lymphoma histologies having a specific degree of differentiation implicit in their ICD-O-2 definitions must be reported with that corresponding differentiation Grade code or one of the cell type origin Grade codes ("5"- "8"). The following histologies are limited to the following Grade codes by this part of the edit:

9693/3	malignant lymphoma, lymphocytic, well differentiated , nodular	valid Grade codes 5-8 or 1
9694/3	malignant lymphoma, lymphocytic, intermediate differentiated , nodular	valid Grade codes 5-8 or 2
9696/3	malignant lymphoma, lymphocytic, poorly differentiated , nodular	valid Grade codes 5-8 or 3

4.) Finally, the edit looks at the reported Behavior Code and reported Histologic Type code. Only certain histologies are listed in ICD-O-2 with a default behavior of "/2". Other histologies cannot be assigned an in situ or non-invasive behavior in the ICD-O-2 coding system. SEER provides the following explanation for this part of the edit:

"In situ" is a concept that only pertains to epithelial neoplasms; therefore, an in situ behavior is not allowed with non-epithelial morphologies, such as sarcomas, leukemias, and lymphomas. In situ behavior is also disallowed for a handful of codes representing epithelial neoplasms which, by their nature, cannot be in situ.

The following Histologic Type codes combined with a Behavior Code of **2** will produce the error message "Invalid Histology for In Situ":

8000neoplasm
8001tumor cells
8002small cell type malignant tumor
8003giant cell type malignant tumor
8004fusiform cell type malignant tumor
8020undifferentiated carcinoma
8021anaplastic carcinoma
8331well differentiated follicular adenocarcinoma
8332trabecular follicular adenocarcinoma
8800-9054sarcomas, fibromas, myomas, mixed & stromal neoplasms, fibroepithelial neoplasms, synovial-like neoplasms, mesothelial neoplasms <u>except</u> cystic mesotheliomas
9062anaplastic seminoma
9082undifferentiated malignant teratoma
9083intermediate malignant teratoma
9110-9491, 9501-9989mesonephromas, blood vessel and lymphatic vessel tumors, bone and tooth tumors, miscellaneous tumors, gliomas, neuroepitheliomatous neoplasms <u>except</u> neuroblastomas, meningiomas, nerve sheath tumors, granular cell tumors & alveolar soft part sarcoma, lymphomas, leukemias, and other related diseases

Only Part 2c of the edit has an over-ride [“Histology” is set to **1** if just this edit is being overridden; it’s set to **3** if this edit and the SEER IF31 edits (on behavior/diagnostic confirmation) are being overridden].

The edit skips if the ICD-O-2 histology is empty.

* Note that the AJCC staging system includes grade codes (GX and G1-G3 or G1-G4), but these are not necessarily identical to the **ICD-O** Grade code collected by the MCR. Page 8 in the 5th Edition AJCC staging manual lists 5 histologic types that are automatically assigned a G4 grade code within the AJCC staging system but, except for undifferentiated carcinomas, the ICD-O Grade is not limited to code **4**.

56B. **Morphology--Type&Behavior ICDO3 (SEER MORPH)**

fields involved: Behavior Code ICD-O-3
Date of Diagnosis (year only)
Grade
Histologic Type ICD-O-3

This is the ICD-O-3 version of the preceding edit.

Part 1) is the same as in the preceding edit.

Part 2) is the same, i.e, it checks for valid ICD-O-3 4-digit histologic type codes. Part 2c) has some exceptions: ICD-O-3 histologies **8442, 8451, 8462, 8472** and **8473** are allowed to have a ICD-O-3 behavior of **/1** if the diagnosis year<**2001**. These codes had invasive ICD-O-2 behaviors.

Part 3a) allows Grades **5 - 8** with ICD-O-3 histologies **9590 - 9948**.

Part 3b) has not been updated for new ICD-O-3 terms with an implied grade. It may be updated in future editions of the edits. ICD-O-2 code 9062/34 has been eliminated from this portion of the edit.

Part 3c) does not apply to this ICD-O-3 version of the edit.

Part 4) is the same, with the corresponding ICD-O-3 codes that cannot be *in situ* being:

8000-8005	8331-8332	9062	9110-9989
8020-8021	8800-9055	9082-9083	

Only Part 2c of the edit has an over-ride [Histology” is set to **1** if just this edit is being overridden; it’s set to **3** if this edit and the SEER IF31 edits (on behavior and diagnostic confirmation) are being overridden]

The edit skips if the ICD-O-3 histology is empty.

57. **Name--Alias (COC)**

field involved: Name--Alias (15 characters long)

This is a simple character check.

The field may contain letters (upper or lower case), embedded spaces, embedded hyphens and apostrophes.

The field cannot contain other symbols or numbers.

The field may be empty.

58. **Name--First (MCR-CIMS)**

field involved: Name--First (14 letters long)

This is a simple character check.

The field may contain letters (upper or lower case) and embedded spaces.

The field cannot contain a leading space, symbols or numbers.

The field cannot be empty.

The ROADS Manual instructs you to leave this field blank if you don't know the patient's first name, and the COC's version of this edit allows the field to be empty. The MCR's data system relies heavily on this field, so a blank first name is useless to us. We modified the COC edit to disallow an empty first name.

59. **Name--Last (MCR-CIMS)**

field involved: Name--Last (25 characters long)

This is a simple character check.

The patient's last name can contain only letters (upper and lower case). It cannot contain numbers, spaces or symbols (including hyphens). If your data systems allows you to enter hyphens or embedded spaces into this field, your system should be removing them in the MCR's version of your case records (i.e., as your cases are exported and sent to a floppy diskette for the MCR, these unwanted characters are taken out. The hyphens and spaces remain as they were entered on your system, but the MCR does not have to remove these characters from your patients' names so that our system can accept them and match them against other facilities' patient names.

The field cannot be empty.

60. **Name--Maiden (MCR-CIMS)**

field involved: Name--Maiden (15 letters long)

This is a simple character check.

If a maiden name is being reported, the field may contain letters only (upper and lower case).

The field cannot contain numbers, spaces or symbols.

The field may be empty.

The ROADS Manual instructs that spaces and symbols are OK in this field, and the COC's version of this edit allows space, hyphens, etc. here. In order to be useful to the MCR as a matching field, we can only allow a maiden name to contain letters. The MCR therefore modified the COC's version of this edit to disallow the symbols, spaces, etc.

Note that no edits check this field against Sex, Marital Status or Age to see if the field is being filled for appropriate patients only.

61. **Name--Middle (NAACCR)**

field involved: Name--Middle (14 characters long)

This is a simple character check.

If a middle name (or initial) is being reported, the field may contain letters only (upper and lower case).

The field cannot contain spaces, symbols or numbers.

The field may be empty.

62. Name--Suffix (COC)

field involved: Name--Suffix (3 letters long)

This is a simple character check.

If a name suffix is being reported, the field may contain letters only (upper and lower case).

The field cannot contain spaces, symbols or numbers.

The field may be empty.

63. Pediatric Stage (NAACCR)

field involved: Pediatric Stage (2 characters long)

This is a simple validity check.

If letters are entered, they must be in upper case only. If only a single character is entered, it belongs on the left side.

The edit compares the reported code with codes stored in a look-up table. Valid codes are:

1_	2_	3_	4_	5_	88
1A	2A	3A	4A	A_	99
1B	2B	3B	4B	B_	
	2C	3C	4S	C_	
		3D		D_	
		3E		DS	

The field cannot be empty.

Note that no edit involving any of the pediatric staging fields checks the patient's age.

64. Pediatric Stage, Pediatric Staging System (COC)

fields involved: Pediatric Stage
Pediatric Staging System

This is a very simple field comparison.

The edit checks that if one of these fields indicates that the case is *not* pediatric (code **88**), then the other field also agrees that it is *not* pediatric. That is, if both fields are coded **88**, the edit will be passed; if one field is **88** and the other is anything but **88**, the edit will fail.

This is all that the edit does. It does not use the patient's reported age or diagnosis to try to verify if an **88** code is being used appropriately. There are no strict code-related definitions of what cases should be classified as pediatric, after all; but even a very typical pediatric case will pass this edit with **88** codes. For example, a retinoblastoma reported in an infant with two 88's in these fields will pass the edit.

The edit is also not comparing the two fields to ensure that the stage reported is a valid code in the staging system reported. Note that no edit involving any of the pediatric staging fields checks the patient's age.

65. Pediatric Staging System (NAACCR)

field involved: Pediatric Staging System (2 digits long)

This is a simple validity check.

Valid codes are **00 - 15, 88, 97** and **99**.

The field cannot be empty.

Note that no edit involving any of the pediatric staging fields checks the patient's age.

66. Place of Death (NAACCR)

field involved: Place of Death (3 digits long)

This is a simple validity check. It uses a look-up table.

Valid codes are in MCR Manual Appendix A. (Codes in Appendix C in the ROADS Manual have not been updated.)

The field cannot be empty, even for living patients (enter code **997** for them).

67. Place of Death, Vital Status (NAACCR)

fields involved: Place of Death
Vital Status

This edit looks for agreement between death place and vital status. It checks that living patients have a death place of “still alive” (**997**), and that dead patients have any other death place.

If Place of Death is coded **997**, Vital Status must be coded **1**. If Place of Death is *not* **997**, Vital Status must be coded **0**.

68. Primary Payer at DX (NAACCR)

field involved: Primary Payer at DX (2 digits)

This is a simple validity check.

Valid codes are:

00	20	30	40	88
01	21	31	41	99
02	22	32	42	
10			43	
			44	
			45	
			46	
			47	

The field cannot be empty.

69. Primary Site (SEER SITE)

field involved: Primary Site (letter “C” followed by 3 digits)

This is a simple validity check. The code reported must be a topography code listed in ICD-O-3.

The edit uses a look-up table of all valid codes.

The field cannot be empty.

70A. Primary Site, Behavior Code (MCR-CIMS/SEER IF39)

fields involved: Behavior (92-00) ICD-O-2
 Histology (92-00) ICD-O-2
 Primary Site

The edit is skipped for a case record if the ICD-O-2 histologic type code is empty. The edit is skipped if either ICD-O-2 Behavior or Primary Site has failed its validity check.

This edit does two different things. It has a SEER check, and a MCR check.

The SEER part of this edit questions a combination of *in situ* behavior and a vague primary site. SEER provides the following explanation and advice:

Since the designation of *in situ* is very specific and almost always requires microscopic confirmation, it is assumed that specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being *in situ* is reliable. Therefore this edit does not allow an *in situ* behavior code to be used with specified organ systems and ill-defined site codes.

...Check the information available about primary site and histologic type carefully. If a specific *in situ* diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system may sometimes be assumed based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is probably preferable to code a behavior code of **3**.

The edit questions the following primary sites when reported with an ICD-O-2 Behavior of **2**:

C269	gastrointestinal tract, NOS	C689	urinary system, NOS
C399	ill-defined sites within respiratory system	C729	nervous system, NOS
C559	uterus, NOS	C759	endocrine gland, NOS
C579	female genital tract, NOS	C76_	ill-defined sites
C639	male genital organs, NOS	C809	unknown primary site

Note that the edit does not look at staging fields. It solely uses the ICD-O-2 Behavior code to determine if the case is being called *in situ* or non-invasive.

The MCR part of this edit questions an uncertain or benign ICD-O-2 behavior with any non-meninges/brain/CNS primary site. Because the MCR collects cases with these behaviors *only* for meninges, brain and other central nervous system primaries, we need an edit to check that these behaviors are not submitted for other sites. The following code combinations are questioned by this part of the edit:

ICD-O-2 Behavior = **0** or **1** and Primary Site <> **C700 - C729** (meninges, brain, other parts of CNS)

This edit has an over-ride (for both parts) called "Site/Behavior".

(There is no logical relationship between the SEER and MCR parts of this edit. The MCR needed an edit to limit certain behaviors to certain primary sites, and this SEER edit just happened to involve the fields necessary to do that.)

70B. Primary Site, Behavior Code ICDO3 (SEER IF39/MCR-

fields involved: Behavior Code ICD-O-3
 Histologic Type ICD-O-3
 Primary Site

This is the ICD-O-3 version of the preceding edit.

It skips if the ICD-O-3 Histology is empty. It skips if the validity check on ICD-O-3 Behavior or Primary Site has failed.

It works just like the preceding SEER/MCR edit, using the ICD-O-3 Behavior instead of the ICD-O-2.

The same over-ride ("Site/Type") applies to this edit.

71. Primary Site, Histology Narratives check(MCR-CIMS)

fields involved: Class of Case
Date of Diagnosis (year only)
Text--Histology Title (40 characters long)
Text--Primary Site Title (40 characters long)

This edit is a simple empty check on the Primary Site and Histology Narratives. It runs only in our Scan Edit Set.

This edit is automatically passed for a case record if the Class code is analytic (**0 - 2**), or the diagnosis year is coded as unknown (**9999**), or diagnosis year is less than **2000**.

Although filling in the primary site and histology narratives was never optional for analytic cases, the MCR has had problems receiving these text fields. We have found it necessary to impose an edit to check that they have been filled in.

For analytic cases and autopsy cases, this edit checks that these two narratives have been filled in whenever the diagnosis date is January 1, 2000 or afterward.

The edit fails if either narrative is empty (or both are empty) and this combination of codes is reported:

diagnosis year > **1999** and Class > **3, 4, 6 or 9**

The same dual error message is generated ("Text--Primary Site Title, Text--Histology Title can not be blank") whether one or both of the narratives is empty.

Note that a case of Class **8** (diagnosis made on death certificate only) is not covered by this edit. Because MCR staff enter the data for Class 8 cases, we feel secure that their narrative fields will not be empty so we do not bother to check them.

If you are entering text into narrative fields but the MCR reports that we are receiving your narratives empty, there may be some kind of problem with your data system or your routine for exporting case records for the MCR. Be sure you know which narrative fields on your system are seen by the MCR.

72A. Primary Site, Morphology-Imposs ICDO3 (SEER IF38)

fields involved: Histologic Type ICD-O-3
Primary Site

This edit skips if the ICD-O-3 Histologic Type code is empty. It skips if either field has failed its validity check.

This edit checks that the ICD-O-3 site/histology codes in a case record do not represent a biologically "impossible" combination. It uses a look-up table of site/histology combinations that SEER considers impossible:

	Primary Site		ICD-O-3 Histologic Type	
1.	C000-C009	Lip	8090-8098	Basal cell carcinoma
2.	C199 C209 C210-C218	Rectosigmoid junction Rectum Anus and anal canal	8090-8098	Basal cell carcinoma
3.	C480-C488	Retroperitoneum and peritoneum	8720-8790	Melanomas
4.	C300 C301 C310-C319	Nasal cavity Middle ear Accessory sinuses	9250-9342	Osteosarcomas (Giant cell, Ewing, odontogenic)
5.	C381-C388	Pleura and mediastinum	8010-8671, 8940-8941 8720-8790	Carcinomas Melanomas
6.	C470-C479 C490-C499	Peripheral nerves Connective tissue	8010-8671, 8940-8941 8720-8790	Carcinomas Melanomas
7.	C700-C709 C710-C719 C720-C729	Meninges Brain Other central nervous system	8010-8671, 8940-8941	Carcinomas
8.	C400-C419	Bone	8010-8060, 8075-8671, 8940-8941 8720-8790	Carcinomas (except squamous cell) Melanomas
9.	C760-C768	Ill-defined sites	8720-8790 8800-8811, 8813-8830, 8840-8921, 9040-9044 8990-8991 8940, 8941 9120-9170 9240-9252 9540-9560 9580-9582	Melanomas Sarcoma except periosteal fibrosarcoma, dermatofibrosarcoma Mesenchymoma Mixed tumor, salivary gland type Blood vessel tumor Mesenchymal chondrosarcoma and giant cell tumors Nerve sheath tumor Granular cell tumor and alveolar soft part sarcoma

SEER offers lots of explanation and repetitive advice to help fix errors found by this edit (numbers in the "Specific Guidelines" section correspond to the row numbers in the table of bad code combinations above):

Combinations of site and type are designated as impossible by this edit because the combination is biologically impossible, i.e., the particular form of cancer does not arise in the specified site, or because standard cancer registry conventions have been established to code certain combinations in certain ways.

...The suggestions below are a starting point for analyzing an error, but are not a substitute for a medical decision.

General Guidelines:

First review the case for the following: 1.) Is the histologic type correctly coded?...Note that the code for "Cancer" and "Malignancy" (8000/3) is NOT interchangeable with the code for "Carcinoma, NOS" (8010/3), which refers only to a malignancy of epithelial origin. 2.) Is the primary site coded correctly? Check whether the site coded...could be instead the site of metastatic spread or the site where a biopsy was performed. If so, check for a more appropriate site.

Specific Guidelines:

1. Lip and Basal Cell Carcinoma: The codes for lip, C00.0-C00.9, are reserved for the vermilion border of the lip and specifically exclude skin of lip (the skin surrounding the vermilion of the lip proper) which has the code C44.0....The two

tissues, vermillion and skin of lip, are distinct, and basal cell carcinoma does not arise on the vermillion portion of the lip. A basal cell carcinoma of the lip should be assumed to have arisen on the skin of lip and be coded to C44.0. This will not be reportable to most cancer registries which do not collect basal cell skin cancers.

2. Rectosigmoid/Rectum/Anus and Basal Cell Carcinoma: There is a form of anal cancer called cloacogenic carcinoma, which is also called basaloid carcinoma, coded 8124 and 8123, respectively, in ICD-O-3. Try to determine if the case has arisen within the anal canal and should be coded 8123 or 8124. It is also possible that the cancer is a basal cell cancer of the SKIN of the anus (perianal skin surrounding the anal opening, which is histologically distinct from the mucous membrane in the interior of the anus). A basal cell carcinoma of the skin of the anus should be coded C44.5, skin of trunk, and is generally not reportable in cancer registries.

3. Retroperitoneum/Peritoneum and Melanomas: If melanoma is identified in peritoneal or retroperitoneal tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the melanoma. If not primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

4. Nasal Cavity/Middle Ear/Accessory Sinuses and Osteosarcomas: Osteosarcomas arise in bone, and the specified site code in ICD-O-3 is C40._ or C41._. Osteosarcomas arising in the areas of the nose, middle ear, and sinuses should be assumed to have arisen in the bones of the skull and their primary site coded C41.0.

5. Pleura/Mediastinum and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in the pleura or mediastinum, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

6. Peripheral Nerves/Connective Tissue and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in peripheral nerves or connective tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

7. Meninges/Brain/Other CNS and Carcinomas: If a carcinoma is identified in the brain, meninges, or other central nervous system, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma. Check that the tumor is indeed a carcinoma and not "Cancer" or "Malignancy" which would be coded 8000/3. If it is a carcinoma and no primary can be determined, code "Unknown primary site", C80.9.

8. Bone and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in bone, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44._, as the appropriate primary site.

9. Ill-defined Sites and Various Histologies: Some histologic types are by convention more appropriately coded to a code representing the tissue in which such tumors arise rather than the ill-defined region of the body, which contains multiple tissues. The table below shows for the histologic types addressed in this edit which site should be used instead of an ill-defined site in the range C76.0-C76.8.

Histologic Type Codes	Histologic Types	Preferred Site Codes for Ill-Defined Primary Sites
8720-8790	melanoma	C44._, skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._, connective, subcutaneous & other soft tissues
8990-8991	mesenchymoma	C49._, connective, subcutaneous & other soft tissues
8940-8941	mixed tumor, salivary gland type	C07._ for parotid gland; C08._ for other & unspecified major salivary glands
9120-9170	blood vessel tumors, lymphatic vessel tumors	C49._, connective, subcutaneous & other soft tissues
9240-9252	mesenchymal chondrosarcoma and giant cell tumors	C40._, C41._ for bone & cartilage; C49._, connective, subcutaneous & other soft tissues
9580-9582	granular cell tumor and alveolar soft part sarcoma	C49._, connective, subcutaneous & other soft tissues

Note that there is NO OVER-RIDE for this edit. When SEER says "impossible", they mean it.

72B. **Primary Site, Morphology-Impossible (SEER IF38)**

fields involved: Histology (92-00) ICD-O-2
Primary Site

This is the ICD-O-2 version of the preceding edit. It skips if ICD-O-2 Histology is empty. It skips if either field has failed its validity check. This is the ICD-O-2 version of the table of site/histology combinations that SEER considers impossible:

	Primary Site		Histologic Type	
1.	C000-C009	Lip	8090-8096	Basal cell carcinoma
2.	C199 C209 C210-C218	Rectosigmoid junction Rectum Anus and anal canal	8090-8096	Basal cell carcinoma
3.	C480-C488	Retroperitoneum and peritoneum	8720-8790	Melanomas
4.	C300 C301 C310-C319	Nasal cavity Middle ear Accessory sinuses	9250-9340	Osteosarcomas (Giant cell, Ewing's, odontogenic)
5.	C381-C388	Pleura and mediastinum	8010-8671, 8940-8941 8720-8790	Carcinomas Melanomas
6.	C470-C479 C490-C499	Peripheral nerves Connective tissue	8010-8671, 8940-8941 8720-8790	Carcinomas Melanomas
7.	C700-C709 C710-C719 C720-C729	Meninges Brain Other central nervous system	8010-8671, 8940-8941	Carcinomas
8.	C400-C419	Bone	8010-8060, 8075-8671, 8940-8941 8720-8790	Carcinomas (except squamous cell) Melanomas
9.	C760-C768	Ill-defined sites	8720-8790 8800-8811, 8813-8830, 8840-8920, 9040-9044 8990-8991 8940, 8941 9120-9170 9240-9251 9540-9560 9580-9581	Melanomas Sarcoma except periosteal fibrosarcoma, dermatofibrosarcoma Mesenchymoma Mixed tumor, salivary gland type Blood vessel tumor Mesenchymal chondrosarcoma and giant cell tumors Nerve sheath tumor Granular cell tumor and alveolar soft part sarcoma

The ICD-O-2 version of the “preferred site” table to replace C76._ looks like this:

Histologic Type Codes	Histologic Types	Preferred Site Codes for Ill-Defined Primary Sites
8720-8790	melanoma	C44._ , skin
8800-8811, 8813-8830, 8840-8920, 9040-9044	sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._ , connective, subcutaneous & other soft tissues
8990-8991	mesenchymoma	C49._ , connective, subcutaneous & other soft tissues
8940-8941	mixed tumor, salivary gland type	C07._ for parotid gland; C08._ for other & unspecified major salivary glands
9120-9170	blood vessel tumors, lymphatic vessel tumors	C49._ , connective, subcutaneous & other soft tissues
9240-9251	mesenchymal chondrosarcoma and giant cell tumors	C40._ , C41._ for bone & cartilage; C49._ , connective, subcutaneous & other soft tissues
9580-9581	granular cell tumor and alveolar soft part sarcoma	C49._ , connective, subcutaneous & other soft tissues

Note that there is NO OVER-RIDE for this edit.

73A. Primary Site, Morphology-Type Check (SEER IF25)

fields involved: Histology (92-00) ICD-O-2
Primary Site

This edit compares the reported ICD-O-2 site/histology code combination with huge look-up tables of site/histology combinations that SEER considers to be compatible (i.e., diagnoses typical for that site). If it does not find the reported site/histology combination in the look-up tables, it questions the reported code combination as "not typical".

The list of "typical" site/histology combinations is too big to include here.

The edit skips if the ICD-O-2 Histology code is empty. The edit skips if either field has failed its validity check.

The edit has an over-ride called "Site/Type".

The COC version of this edit considers basal and squamous cell carcinomas of non-genital skin sites to be valid site/histology combinations (because these skin cancers are now reportable under COC rules if the stage at diagnosis was at least a Stage Group II with a T3). This SEER version of the edit does *not* consider such cancers to be valid site/histology combinations because they are not reportable to SEER. The MCR uses the SEER version of the edit because these skin cancers are also non-reportable to us. We rely on this edit to stop those diagnoses from getting onto our main data system.

73B. Primary Site, Morphology-Type ICDO3 (SEER IF25)

fields involved: Histologic Type ICD-O-3
Primary Site

This is the ICD-O-3 version of the preceding edit. It skips if the ICD-O-3 Histologic Type code is empty or if either field has failed its validity check.

A table (in .pdf and Excel versions) representing the ICD-O-3 site/histology combinations that SEER considers typical is available at the SEER website/Administration section: <http://seer.cancer.gov/Admin>. It is under "ICD-O-3 SEER Site/Histology Validation List - 6/14/2001". It is sorted by site. It can be helpful to download this table (right-click on it and use "save target as....") so that you can search for an unusual histology code (in a text editor or software like Excel or Word) and see what sites SEER considers compatible with that histology.

The "Site/Type" over-ride also applies to this edit.

74A. **Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR)**

fields involved: Date of Diagnosis (year only)
 Histologic Type ICD-O-3
 Primary Site
 TNM Clin T
 TNM Clin N
 TNM Clin M
 TNM Clin Stage Group
 TNM Path T
 TNM Path N
 TNM Path M
 TNM Path Stage Group

This edit checks that sites with NO staging scheme in the *AJCC Cancer Staging Manual, Fifth Edition* have TNM fields filled with the “not applicable” code (**88**).

The edit skips if the ICD-O-3 Histologic Type code is empty. It skips for lymphomas (9590-9699, 9702-9729) because they should *not* have **88** in the Stage Group fields. It also skips if the year of diagnosis is before 1998 (when the *Fifth Ed.* became applicable).

If the Primary Site is one of these codes:

C173	Meckel diverticulum, small intestine
C254	islets of Langerhans, pancreas
C260, C268, C269	other and ill-defined digestive organs
C300, C301	nasal cavity and middle ear
C312, C313, C318, C319	accessory sinuses: frontal, sphenoid, overlapping lesion, NOS
C339	trachea
C379	thymus
C390, C398, C399	other and ill-defined sites within respiratory system and intrathoracic organs
C420-C424	hematopoietic and reticuloendothelial systems
C571-C574, C577-C579	other and unspecified female genital organs except fallopian tube
C630, C631, C637-C639	other and unspecified male genital organs except scrotum
C691, C699	cornea, NOS; eye, NOS
C700, C701, C709	meninges
C710-C719	brain
C720-C725, C728-C729	spinal cord, cranial nerves, and other parts of central nervous system
C740, C741, C749	adrenal gland
C750-C755, C758, C759	other endocrine glands and related structures
C760-C765, C767, C768	other and ill-defined sites
C809	unknown primary site

then the clinical TNM Elements, clinical Stage Group, pathologic TNM Elements and Pathologic Stage Group must all be coded **88**. If any of these fields is not **88**, the edit will fail.

Note that there is no version of this edit for previous editions of the AJCC staging manual. This edit assumes that the *Fifth Edition* of the AJCC staging manual was used for any case diagnosed in 1998 and later. This edit only checks for sites which have NO *Fifth Ed.* staging scheme at all (for any histology). Sites not listed above which *do* have a staging scheme in the *Fifth Ed.* will also require **88** in the TNM and Stage Group fields if the scheme does not apply to the particular case's histology.

74B. Primary Site, No AJCC Staging Scheme-Ed 5 (NAACCR)

fields involved: Date of Diagnosis (year only)
 Histology (92-00) ICD-O-2
 Primary Site
 TNM Clin T
 TNM Clin N
 TNM Clin M
 TNM Clin Stage Group
 TNM Path T
 TNM Path N
 TNM Path M
 TNM Path Stage Group

This edit skips for lymphomas defined by the ICD-O-2 Histology codes **9590 - 9698, 9702 - 9717**, and it skips when the ICD-O-2 Histology code is empty. Otherwise, it is exactly the same as the preceding edit.

75. Race 1 (SEER RACE)

field involved: Race 1 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 - 32
96 - 99

The field cannot be empty.

76. Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR)

fields involved: Race 1
 Race 2
 Race 3
 Race 4
 Race 5

This edit compares the codes in all five race fields to see if any of their basic coding rules are violated. Race 1 cannot be empty, but it is possible to fill only Race 1 and leave the remaining Race fields empty (for pre-2000 diagnoses). If Race 1 is unknown and the other Race fields are filled in, they must also be unknown. When the patient's races have been specified fully, then all subsequent Race fields must be coded "no further races documented" (**88**). A particular Race code (other than spaces, **88** or **99**) can only be used once.

If Race 2 is empty, then Race 3, Race 4 and Race 5 must be empty.

If Race 1=**99** and the other Race fields are not empty, they must all be **99**.

If Race 2=**88** then Race 3 must be **88**; if Race 3=**88** then Race 4 must be **88**; if Race 4=**88** then Race 5 must be **88**.

Unless it's **99**, the Race 1 code cannot be identical to Race 2, Race 3, Race 4 or Race 5; unless it's **88** or empty, the Race 2 code cannot be identical to Race 3, Race 4 or Race 5; except for **88** or empty fields, the Race 3 code cannot be identical to Race 4 or Race 5; except for **88** or empty fields, the Race 4 code cannot be identical to the Race 5 code.

77. **Race 2 (NAACCR)**

field involved: Race 2 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 - 32
88
96 - 99

The field can also be empty or consist of two spacebars (blank spaces).

78. **Race 2, Date of DX (NAACCR)**

fields involved: Date of Diagnosis (year only)
Race 2

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 2 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 2 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

79. **Race 3 (NAACCR)**

field involved: Race 3 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 - 32
88
96 - 99

The field can also be empty or two spacebars (blank spaces).

80. **Race 3, Date of DX (NAACCR)**

fields involved: Date of Diagnosis (year only)
Race 3

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 3 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 3 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

81. Race 4 (NAACCR)

field involved: Race 4 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 - 32
88
96 - 99

The field can also be empty or two spacebars (blank spaces).

82. Race 4, Date of DX (NAACCR)

fields involved: Date of Diagnosis (year only)
Race 4

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 4 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 4 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

83. Race 5 (NAACCR)

field involved: Race 5 (2 digits long)

This is a simple validation check.

Valid codes are: **01 - 14**
20 - 22
25 - 28
30 - 32
88
96 - 99

The field can also be empty or 2 spacebars (blank spaces).

84. Race 5, Date of DX (NAACCR)

fields involved: Date of Diagnosis (year only)
Race 5

Multiracial coding became valid as of diagnosis year 2000. This edit checks that Race 5 is filled for diagnosis years 2000 and thereafter. (For diagnoses made before 2000, the field may be empty or filled.)

If the year of Diagnosis > **1999**, Race 5 must not be empty.

If the Date of Diagnosis is completely unknown (year = **9999**), the edit skips.

85. Reason for No Surgery (SEER NCDSURG)

field involved: Reason for No Surgery (1 digit long)

This is a simple validity check.

Valid codes are **0, 1, 2, 6, 7, 8** and **9**.

The field cannot be empty.

86. Regional Nodes Ex, Reg Nodes Pos (COC)

fields involved: Regional Nodes Examined
Regional Nodes Positive

This edit fails if there is a conflict between the codes in these two fields. Basically, the total number of nodes found to be positive cannot exceed the total number of nodes that were examined. The edit is quite complex, however, because the coding systems for the two fields do not correspond as much as one might expect.

Listed below are all possible code combinations between the two fields. They are listed numerically by the code in Regional Nodes Examined, followed by the code(s) for Regional Nodes Positive that the edit will accept in that situation.

If Regional Nodes Examined is **00** (no nodes removed), then Regional Nodes Positive can only be **98** (no nodes removed).

If Regional Nodes Examined is **01 - 89** (a specific number of nodes were removed), then Regional Nodes Positive may be

00 - 89 (that specific number of nodes were positive) or

97 (there were positive nodes, but the exact number is unknown) or

99 (nodes were examined, but it's unknown if any were positive).

If both fields contain specific numbers of nodes, then Regional Nodes Examined must be \geq Regional Nodes Positive.

If Regional Nodes Examined = **90** (ninety or more nodes were removed), then Regional Nodes Examined may be

00 - 95 (that specific number of nodes were positive) or

96 (ninety-six or more nodes were positive) or

97 (there were positive nodes, but the exact number is unknown) or

99 (nodes were examined, but it's unknown if any were positive).

That is, Regional Nodes Positive may be any code except **98** (no nodes were removed).

If Regional Nodes Examined is **95** (node aspiration), then Regional Nodes Positive may be

00 (all nodes examined were negative) or

97 (there were positive nodes, but the exact number is unknown) or

99 (nodes were examined, but it's unknown if any were positive).

If Regional Nodes Examined is coded

96 (nodes were sampled, exact number unknown) or

97 (nodes were dissected, exact number unknown) or

98 (nodes were removed surgically, sampling/dissection not specified, exact number unknown),

then Regional Nodes Positive may be any code except **98** (no nodes were removed).

If Regional Nodes Examined is **99** (not applicable, complete unknown), then Regional Nodes Positive can only be **99** also.

Given the limitations of the codes, this is as specific as the edit can get in looking for conflict between the two fields.

Note that the edit performs no comparisons against the fields RX Summ--Reg LN Removed and RX Hosp--Reg LN Removed because the values in the surgical fields are not expected to always agree with the staging node fields. The rules for coding the two sets of fields are quite different.

87. Regional Nodes Examined (COC)

field involved: Regional Nodes Examined (2 digits long)

This is a simple validity check.

Valid codes are **00 - 90** or **95 - 99** (any 2 digits but **91 - 94**).

The field cannot be empty.

88. Regional Nodes Positive (COC)

field involved: Regional Nodes Positive (2 digits long)

This is a simple validity check.

Valid codes are **00 - 99** (any 2 digits).

The field cannot be empty.

89. RML Lung, Laterality (NAACCR)

fields involved: Laterality
Primary Site

The left lung has no middle lobe (C34.2). This edit checks that C34.2 is not coded with a left Laterality.

If Primary Site = **C342** then Laterality \neq **2**.

Although only the right lung has a middle lobe, *any* paired Laterality other than the left code is permitted by this edit. The edit will allow a cancer to begin in the middle lobe of a lung whose Laterality is not known (**3, 4**), or when the Laterality is completely unknown (**9**). We would expect that if you know a cancer originated in a middle lobe, then you must assume that the Primary Site must be the right lung!

90. RX Date--BRM (NAACCR)

field involved: RX Date--BRM (8 digits long)

This is a treatment date validity check. All validity checks on treatment dates collected by the MCR behave in this way.

Error messages are "##### is an invalid date", "invalid as to year", "invalid as to month", "invalid as to day"*, "missing the year", "missing the month" and "missing the day". The particular message you may see depends on the type of error found by the edit.

If the year is coded **0000**, then the entire date must be filled with 8 zeroes. If the year alone is **0000** (with a valid month and day filled in), you will get the "missing the year" error message. A month or day code alone of **00** (with a valid year) generates the "missing the month" or "missing the day" message.

The field cannot be empty. (The COC version of this edit allows it to be empty.)

* Actually, you will see "invalid as *today*" because of a typo in the error message.

91. RX Date--Chemo (NAACCR)

field involved: RX Date--Chemo (8 digits long)

This is a treatment date validity check. See the description of Edit #90 on page E-76. It does the same thing using a different treatment date field.

92. RX Date—DX/Stg/Pall Proc (NAACCR)

field involved: RX Date—DX/Stg/Pall Proc (8 digits long)

This is a treatment date validity check. See the description of Edit #90 on page E-76. It does the same thing using a different treatment date field.

93. RX Date--Hormone (NAACCR)

field involved: RX Date--Hormone (8 digits long)

This is a treatment date validity check. See the description of Edit #90 on page E-76. It does the same thing using a different treatment date field.

94. RX Date--Other (NAACCR)

field involved: RX Date--Other (8 digits long)

This is a treatment date validity check. See the description of Edit #90 on page E-76. It does the same thing using a different treatment date field.

95. RX Date--Radiation (NAACCR)

field involved: RX Date--Radiation

This is a treatment date validity check. See the description of Edit #90 on page E-76. It does the same thing using a different treatment date field.

96. RX Date--Surgery (NAACCR)

field involved: RX Date--Surgery (8 digits long)

This is a treatment date validity check. See the description of Edit #90 on page E-76. It does the same thing using a different date treatment field.

97. RX Date--Surgery, RX Text--Surgery (NAA/MCR-CIMS)

fields involved: Class of Case
 RX Date--Surgery
 RX Text--Surgery

This edit checks that the surgery narrative has been filled in when surgery has been done. For simplicity, the edit uses just the surgery date field to determine if surgery has been done. This edit runs only in our Scan Edit Set.

If the surgery date is zero-filled (cancer-directed surgery was not done) or is 9-filled (completely unknown date), the edit passes without checking to see if there is any surgery narrative.

If the date is anything but **00000000** or **99999999**, the narrative cannot be empty.

Because the MCR does not require narratives for most non-analytic cases, the edit skips whenever Class of Case = **3, 4, 6** or **9**. It also skips if the surgery start date is empty.

Note that this narrative field should also contain text describing any non cancer-directed surgical procedures (diagnostic/staging/palliative surgical procedures). If no cancer-directed surgery was done, the edit does not check to see if diagnostic/staging/palliative procedures were done; the edit will allow the narrative field to be empty in such cases.

98. RX Hosp--BRM (NAACCR)

field involved: RX Hosp--BRM (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit).

The field cannot be empty.

99. RX Hosp--BRM, RX Summ--BRM (COC)

fields involved: RX Hosp--BRM
 RX Summ--BRM

This edit checks for basic agreement between the two fields. The edit is skipped for a case record if either field is empty.

If the hospital field indicates that some treatment was done (or was refused, or recommended, or may have been recommended/done), then the summary field cannot indicate that none was done. That is, if the hospital field is **> 0** then the summary field must also be **> 0**.

If the hospital field indicates that some kind of immunotherapy was done here (**1 - 6**), then the summary field cannot indicate that no immunotherapy at all was given (**0**) or that immunotherapy may have been recommended/done (**9**).

The edit does not go any further to test the compatibility of the two codes. For example, if the hospital code indicates combination immunotherapy (**6**) and the summary code indicates some single therapy only, the edit does not mind.

100. RX Hosp--Chemo (NAACCR)

field involved: RX Hosp--Chemo (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** or **9**.

The field cannot be empty.

101. RX Hosp--Chemo, RX Summ--Chemo (COC)

fields involved: RX Hosp--Chemo
RX Summ--Chemo

This edit checks for basic agreement between the two fields.

The edit is skipped for a case record if either field is empty.

If the hospital code indicates that some kind of chemo was done (or may have been recommended/done), then the summary code cannot indicate that none was done. That is, if the hospital code is > **0**, then the summary code must also be > **0**.

If the hospital code indicates that chemo was done, then the summary code cannot indicate that none was done or that some may have been recommended/done. That is, if the hospital code is **1 - 3**, then the summary code can't be **0** or **9**.

The edit does not look for any further consistency between the fields. For example, if the hospital indicates that multiple agents were given here (**3**) and the summary indicates that a single agent was given (**2**), the edit does not mind.

102. RX Hosp--DX/Stg/Pall Proc (NAACCR)

field involved: RX Hosp--DX/Stg/Pall Proc (2 digits long)

This is a simple validity check.

Valid codes are **00 - 07** or **09**.

The field cannot be empty.

103. RX Hosp--DX/Stg/Pall, RX Summ--DX/Stg/Pall (NAACCR)

fields involved: RX Hosp--DX/Stg/Pall Proc
RX Summ--DX/Stg/Pall Proc

This edit looks for basic agreement between the two fields. The edit skips for a case record if the hospital field is empty.

If the hospital field indicates that some kind of procedure(s) was done or may have been done, then the summary field cannot indicate that none was done. That is, if the hospital field is > **00** then the summary field must also be > **00**.

If the hospital field indicates that some procedure(s) was done (**01 - 07**), then the summary field cannot indicate that none was done (**00**) or that some may have been done (**09**).

The edit does not look for any greater consistency between the two fields. For example, if the hospital field indicates a biopsy plus a bypass and the summary field indicates just a biopsy, the edit does not mind.

104. RX Hosp--Hormone (NAACCR)

field involved: RX Hosp--Hormone (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** or **9**.

The field cannot be empty.

105. RX Hosp--Hormone, RX Summ--Hormone (COC)

fields involved: RX Hosp--Hormone
RX Summ--Hormone

This edit checks for basic agreement between the two fields.

The edit is skipped for a case record if either field is empty.

If the hospital code indicates that some treatment was done (or may have been recommended/done), then the summary code cannot indicate that none was done. That is, if the hospital code is > **0** then the summary code must also be > **0**.

If the hospital code indicates that some treatment was done here (**1 - 3**), then the summary code cannot indicate that none was done (**0**) or that some may have been recommended/done (**9**).

The edit does not check for further discrepancies between the two fields. If the hospital code indicates combination therapy (**3**) and the summary code indicates a single type of treatment (**1** or **2**), the edit does not mind.

106. RX Hosp--Other (NAACCR)

field involved: RX Hosp--Other (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** and **6 - 9**.

The field cannot be empty.

107. RX Hosp--Other, RX Summ--Other (COC)

fields involved: RX Hosp--Other
RX Summ--Other

This edit checks for basic agreement between the two fields.

The edit is skipped for a case record if either field is empty.

If the hospital field indicates that some therapy was given (or was refused, or recommended, or may have been recommended/done), then the summary field cannot indicate that none was done or that some may have been recommended/done. That is, if the hospital field is > **0** then the summary field must also be > **0**.

If the hospital field indicates that some therapy was given (**1 - 6**), then the summary field cannot indicate none given (**0**) or some may have been recommended/given (**9**).

108. RX Hosp--Radiation (NAACCR)

field involved: RX Hosp--Radiation (1 digit long)

This is a simple validity check.

Valid codes are **0 - 5** or **9**.

The field cannot be empty.

109. RX Hosp--Radiation, RX Summ--Radiation (COC)

fields involved: RX Hosp--Radiation
RX Summ--Radiation

This edit checks for basic agreement between the two fields.

The edit is skipped if either field is empty.

If the hospital field indicates that radiation was done or may have been done, then the summary field cannot indicate that none was done. That is, if the hospital field is > 0 then the summary field must also be > 0.

If the hospital field indicates that radiation was done (1 - 5), then the summary field cannot indicate that none was done (0) or may have been done (9).

The edit does not check the combination of the two codes further. For example, if the hospital code indicates that multiple types of radiation were given (4), and the summary code indicates that only one type was given, the edit does not mind.

110. RX Hosp--Reg LN Examined (NAACCR)

field involved: RX Hosp--Reg LN Examined (2 digits long)

This is a simple validity check.

Valid codes are 00 - 90 or 95 - 99.

The field cannot be empty.

Note that the *surgical* regional node fields are not checked against the *staging* node fields.

111. RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC)

fields involved: RX Hosp--Scope Reg LN Sur
RX Summ--Scope Reg LN Sur

This edit checks for basic agreement between the two fields. The edit skips for a case record if the hospital field is empty.

If the hospital code indicates that regional lymph node surgery was done or is 9, then the summary code cannot indicate that no node surgery was done. That is, if the hospital code is > 0, then the summary code must also be > 0.

If the hospital code indicates that regional lymph node surgery was done (1 - 8), then the summary code cannot indicate that none was done (0) or that it's unknown (9).

The edit does not check the primary site and does not limit its code comparisons to only codes that are valid for that primary site. Note that the *surgical* regional node fields are not checked against the *staging* node fields by any edit.

112. RX Hosp--Scope Reg LN Sur (NAACCR)

field involved: RX Hosp--Scope Reg LN Sur (1 digit long)

This is a simple validity check.

Valid codes are 0 - 9 (any single digit).

The field cannot be empty.

Note that the *surgical* regional node fields are not checked against the *staging* node fields.

113. **RX Hosp--Scope Reg LN Sur, Primary Site (COC)**

fields involved: Primary Site
RX Hosp--Scope Reg LN Sur

The edit checks that the RX Hosp--Scope Reg LN Sur is a valid code for the primary site. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS Manual. The edit consults a look-up table of valid codes.

The edit is skipped for a case record if RX Hosp--Scope Reg LN Sur is empty.

Note that the *surgical* regional node fields are not checked against the *staging* node fields by any edit.

114. **RX Hosp--Scope Reg LN Sur,RX Hosp--Reg LN Ex (COC)**

fields involved: RX Hosp--Reg LN Examined
RX Hosp--Scope Reg LN Sur
Year First Seen This CA

This edit looks for compatibility between RX Hosp--Scope Reg LN Sur and RX Hosp--Reg LN Examined.

The edit skips a case record whenever the Year First Seen This CA was before 1998.

If the Scope code indicates that no regional node surgery was done (**0**), then the Examined code must indicate that no nodes were surgically removed (**00**) or that nodes were only aspirated (**95**).

If the Scope code indicates that node surgery was done (**1 - 8**), then the Examined code must indicate that a definite number of nodes were removed (**01 - 90**) or that some indefinite number were surgically removed (**96 - 98**).

If the Scope code is completely unknown (**9**), then the Examined code can only be unknown (**99**).

Note that the *surgical* regional node fields are not checked against the *staging* node fields by any edit.

115. **RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC)**

fields involved: RX Hosp--Surg Oth Reg/Dis
RX Summ--Surg Oth Reg/Dis

This edit looks for basic agreement between the two fields.

The edit is skipped for a case record if the hospital field is empty.

If the hospital code indicates that such surgery was done or if it's unknown, then the summary code cannot indicate that no such surgery was done. That is, if RX Hosp--Surg Oth Reg/Dis is > 0 , then RX Summ--Surg Oth Reg/Dis must also be > 0 .

If the hospital code indicates that some such definite surgery was done (**1 - 8**), then the summary code cannot indicate that none was done (**0**) or that it's unknown (**9**).

The edit does not look for any more detailed consistency between the two codes.

116. RX Hosp--Surg Oth Reg/Dis (NAACCR)

field involved: RX Hosp--Surg Oth Reg/Dis (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit).

The field cannot be empty.

117. RX Hosp--Surg Oth Reg/Dis, Primary Site (COC)

fields involved: Primary Site
RX Hosp--Surg Oth Reg/Dis

The edit checks that the RX Hosp--Surg Oth Reg/Dis is a valid code for the primary site. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS Manual. The edit consults a look-up table of valid codes.

The edit is skipped for a case record if the surgical field is empty.

118. RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC)

fields involved: RX Hosp--Surg Prim Site
RX Summ--Surg Prim Site

This edit checks for basic agreement between the two fields.

The edit is skipped for a case record if the hospital field is empty.

If the hospital code indicates that primary site surgery was done or if it's unknown (any code greater than **00**), then the summary code cannot indicate that none was done (**00**).

If the hospital code indicates that primary site surgery was done (**10 - 90**), then the summary code cannot indicate that none was done (**00**) or that it's unknown if it was done (**99**).

The edit does not do any more detailed checking. If the hospital code indicates that an extensive procedure was performed and the summary code indicates that only a small excision was done, the edit does not mind.

119. RX Hosp--Surg Prim Site (NAACCR)

field involved: RX Hosp--Surg Prim Site (2 digits long)

This is a simple validity check.

Valid codes are **00, 10 - 90** and **99**.

The field cannot be empty.

120. RX Hosp--Surg Prim Site, Primary Site (COC)

fields involved: Primary Site
RX Hosp--Surg Prim Site

The edit checks that the RX Hosp--Surg Prim Site is a valid code for the primary site. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS Manual. The edit consults a look-up table of valid codes.

The edit is skipped for a case record if the surgical field is empty.

121. RX Summ--BRM (COC)

field involved: RX Summ--BRM (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit).

The field cannot be empty.

122. RX Summ--BRM, RX Date--BRM (COC)

fields involved: RX Date--BRM (year only)
RX Summ--BRM

This edit checks for conflict between the two fields. It skips for a case record if the date field is empty.

If the treatment code indicates that no immunotherapy was given or was refused (**0** or **7**), then the date field must be filled with zeroes to indicate that no therapy was done.

If the treatment code indicates that immunotherapy was done (**1 - 6**), or if it's unknown whether it was recommended or done (**9**), then the date field cannot be filled with zeroes to indicate that it definitely wasn't done.

If the treatment code indicates that immunotherapy was recommended but it's unknown if it was done (**8**), the date must be filled with zeroes or nines.

If it's unknown whether or not the treatment was recommended/given (**9**), then the date must be filled with nines.

123. RX Summ--BRM, RX Text--BRM (NAACCR/MCR-CIMS)

fields involved: Class of Case
RX Summ--BRM
RX Text--BRM

This edit checks that the immunotherapy narrative has been filled in when Immunotherapy was given. It runs only in our Scan Edit Set.

If the summary code indicates that immunotherapy was given (**1 - 6**), then the narrative cannot be empty.

Because the MCR does not require narratives for most nonanalytic cases, the edit skips whenever Class of Case = **3, 4, 6** or **9**.

124. RX Summ--Chemo (COC)

field involved: RX Summ--Chemo (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** and **9**.

The field cannot be empty.

125. RX Summ--Chemo, RX Date--Chemo (COC)

fields involved: RX Date--Chemo (year only)
RX Summ--Chemo

This edit checks that there is not conflict between the chemotherapy start date and the summary code. It runs only in our Scan Edit Set.

If the summary code indicates chemotherapy was not done (**0**), then the year code must also indicate none done (**0000**).

If the summary code indicates that chemotherapy was done (**1 - 3**), then the year coded cannot indicate that it wasn't done (that is, the date must not be zero-filled).

If the summary code indicates that it's unknown if chemotherapy was recommended/done (**9**), then the date must be **9**-filled.

The edit skips for a case record if the date field is empty.

126. RX Summ--Chemo, RX Text--Chemo (NAACCR/MCR-CIMS)

fields involved: Class of Case
RX Summ--Chemo
RX Text--Chemo

This edit checks that the chemotherapy narrative has been filled in when chemotherapy was given.

If the summary code indicates that chemotherapy was given (**1 - 3**), then the narrative cannot be empty.

Because the MCR does not require narratives for most nonanalytic cases, the edit skips when Class of Case = **3, 4, 6** or **9**.

127. RX Summ--DX/Stg/Pall Proc (COC)

field involved: RX Summ--Non-CA Dir Surg (2 digits long)

This is a simple validity check.

Valid codes are **00 - 07** and **09**.

The field cannot be empty.

128. RX Summ--DX/Stg/Pall, RX Date--DX/Stg/Pall (NAACCR)

fields involved: RX Date--DX/Stg/Pall Proc (year only)
RX Summ--DX/Stg/Pall Proc

This edit checks that there is not conflict between the date field and summary code. It skips if the date field is empty.

If the summary code indicates that no diagnostic/staging/palliative procedure was done (**00**), then the year coded must also indicate that none was done (**0000**).

If the summary code indicates that a procedure(s) was done (**01 - 07**), then the year coded cannot indicate that it wasn't done (that is, the date must not be zero-filled).

If the summary code indicates that it's unknown if a procedure was done (**09**), then the date must be **9**-filled.

129. RX Summ--Hormone (COC)

field involved: RX Summ--Hormone (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** and **9**.

The field cannot be empty.

130. RX Summ--Hormone, RX Date--Hormone (COC)

fields involved: RX Date--Hormone (year only)
RX Summ--Hormone

This edit checks that there is not conflict between the hormone therapy start date and the summary code. It skips for a case record if the date field is empty. It runs only in our Scan Edit Set.

If the summary code indicates that hormone therapy was not done (**0**), then the year coded must also indicate that none was done (**0000**).

If the summary code indicates that hormone therapy was done (**1 - 3**), then the year coded cannot indicate that it wasn't done (that is, the date must not be zero-filled).

If the summary code indicates that it's unknown if hormone therapy was recommended/done (**9**), then the date must be **9**-filled.

131. RX Summ--Hormone, RX Text--Hormone (NAAC/MCR-CIMS)

fields involved: Class of Case
RX Summ--Hormone
RX Text--Hormone

This edit checks that the hormone therapy narrative has been filled in when such therapy was given.

If the summary code indicates that hormone therapy was given (**1 - 3**), then the narrative cannot be empty.

Because the MCR does not require narratives for most nonanalytic cases, the edit skips when Class of Case = **3, 4, 6** or **9**.

132. **RX Summ--Other (COC)**

field involved: RX Summ--Other (1 digit long)

This is a simple validity check.

Valid codes are **0 - 3** and **6 - 9**.

The field cannot be empty.

133. **RX Summ--Other, RX Date--Other (COC)**

fields involved: RX Date--Other (year only)
RX Summ--Other

This edit checks that there is not conflict between the "other" cancer-directed therapy start date and the summary code. It skips for a case record if the date field is empty.

If the summary code indicates that other cancer-directed therapy was not done (**0**) or was not done because it was refused (**7**), then the year coded must also indicate that none was done (**0000**).

If the summary code indicates that other cancer-directed therapy was done (**1 - 3** or **6**), then the year coded cannot indicate that it wasn't done (that is, the date must not be zero-filled).

If the summary code indicates that other cancer-directed therapy was recommended but it's unknown whether it was ever done (**8**), then the year coded may be zero-filled or **9**-filled.

If the summary code indicates that it's unknown if other cancer-directed therapy was recommended/done (**9**), then the date must be **9**-filled.

134. **RX Summ--Other, RX Text--Other (NAA/MCR-CIMS)**

fields involved: Class of Case
RX Summ--Other
RX Text--Other

This edit checks that the other cancer-directed therapy narrative has been filled in when such therapy was given. It runs only in our Scan Edit Set.

If the summary code indicates that therapy was given (**1 - 3** or **6**), then the narrative cannot be empty.

Because the MCR does not require narratives for most nonanalytic cases, the edit skips when Class of Case = **3, 4, 6** or **9**.

135. **RX Summ--Radiation (COC)**

field involved: RX Summ--Radiation (1 digit long)

This is a simple validity check.

Valid codes are **0 - 5** and **9**.

The field cannot be empty.

136. RX Summ--Radiation, RX Date--Radiation (COC)

fields involved: RX Date—Radiation (year only)
RX Summ--Radiation

This edit checks that there is not conflict between the radiation therapy start date and the summary code. The edit skips if the date field is empty.

If the summary code indicates that radiation was not done (**0**), then the year code must also indicate none was done (**0000**).

If the summary code indicates that radiation was done (**1 - 5**), then the year coded cannot indicate that it wasn't done (that is, the date must not be zero-filled).

If the summary code indicates that it's unknown if radiation was recommended/done (**9**), then the date must be **9**-filled.

137. RX Summ--Reconstruct 1st (NAACCR)

field involved: RX Summ--Reconstruct 1st (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit).

The field cannot be empty.

138. RX Summ--Reconstruct 1st, Primary Site (COC)

fields involved: Primary Site
RX Summ--Reconstruct 1st

This edit checks that the first-course therapy reconstruction code is valid for the primary site. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS Manual. The edit consults a look-up table of valid codes.

The edit skips for a case record if the reconstruction code is empty.

139. RX Summ--Reg LN Examined (COC)

field involved: RX Summ--Reg LN Examined (2 digits long)

This is a simple validity check.

Valid codes are **00 - 90** and **95 - 99**.

The field cannot be empty.

140. RX Summ--Scope Reg LN Sur (COC)

field involved: RX Summ--Scope Reg LN Sur (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit).

The field cannot be empty.

141A. RX Summ--Scope Reg LN Sur, Primary Site (COC)

fields involved: Histology (92-00) ICD-O-2
 Primary Site
 RX Summ--Scope Reg LN Sur
 Year First Seen This CA

This edit checks that the summary regional node surgery code is valid for the diagnosis coded. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS. The edit consults a look-up table of valid codes.

If Year First Seen for This Cancer > **1999**, then the regional node surgery code can only be **9** for leukemias (**9800-9941**), nodal lymphomas (**C77_** with **9590-9698, 9702-9717**), brain primaries (**C700, C71_**), and unknown primaries (**C809**).

The edit skips for a case record if the ICD-O-2 histology code is empty.

141B. RX Summ--Scope Reg LN Sur, Primary Site, ICDO3(COC)

fields involved: Histologic Type ICD-O-3
 Primary Site
 RX Summ--Scope Reg LN Sur
 Year First Seen This CA

This is the ICD-O-3 version of the preceding edit. It behaves just like the preceding edit, but the leukemias are defined by code range **9800 - 9989** and the nodal lymphomas are defined by **9590 - 9699, 9702 - 9729**.

The edit skips if the ICD-O-3 histology code is empty.

142. RX Summ--Scope Reg LN Sur, RX Summ--Reg LN Ex (NPCR)

fields involved: Date of Diagnosis (year only)
 RX Summ--Reg LN Examined
 RX Summ--Scope Reg LN Sur

This edit looks for compatibility between the summary fields for scope of node surgery and number of nodes removed.

This edit is skipped whenever the case record's year of diagnosis is less than **1998**.

If the summary "scope" code indicates that no regional node surgery was done (**0**), then the summary number of nodes removed must indicate that none were removed surgically (**00**) or that some were aspirated only (**95**).

If the summary "scope" code indicates that regional node surgery was done (**1 - 8**), then the summary number of nodes must be a specific number surgically removed (**01 - 90**) or an unknown number surgically removed (**96 - 98**).

If the summary "scope" code indicates that it's unknown if node surgery was done (**9**), then the unknown code must also be coded for the summary number of nodes removed (**99**).

143. RX Summ--Surg Oth Reg/Dis (COC)

field involved: RX Summ--Surg Oth Reg/Dis (1 digit long)

This is a simple validity check.

Valid codes are **0 - 9** (any single digit).

The field cannot be empty.

144. RX Summ--Surg Oth Reg/Dis, Primary Site (COC)

fields involved: Primary Site
RX Summ--Surg Oth Reg/Dis

This edit checks that the RX Summ--Surg Oth Reg/Dis code is a valid code for the primary site coded. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS Manual. The edit consults a look-up table of codes.

145. RX Summ--Surg Prim Site (COC)

field involved: RX Summ--Surg Prim Site (2 digits long)

This is a simple validity check.

Valid codes are **00, 10 - 90** and **99**.

The field cannot be empty.

146. RX Summ--Surg Prim Site, Diag Conf (SEER IF76)

fields involved: Diagnostic Confirmation
RX Summ--Surg Prim Site

This edit questions a case record whenever primary site surgery was done but the diagnosis was not microscopically confirmed. The edit asks for review of a case when it sees this combination of codes:

RX Summ--Surg Prim Site = **10-90** and Diagnostic Confirmation <> **1, 2, or 4**

This edit has an over-ride ("Surg/DxConf").

Note that this edit used to check the diagnostic confirmation code against *all* of the cancer-directed summary surgery fields (in the Version 6 edits); now it is limited to just the primary site surgery.

147. RX Summ--Surg Prim Site, Primary Site (COC)

fields involved: Primary Site
RX Summ--Surg Prim Site

This edit checks that the summary primary site surgery code is valid for the primary site. Valid codes are in Appendix D of the MCR Manual and Appendix D of the ROADS Manual. The edit consults a look-up table of valid codes.

148. RX Summ--Surg/Rad Seq (SEER RADSEQ)

field involved: RX Summ--Surg/Rad Seq (1 digit long)

This is a simple validity check.

Valid codes are **0, 2 - 6** and **9**.

The field cannot be empty.

149. **Sequence Number--Hospital (COC)**

field involved: Sequence Number--Hospital (2 characters long)

This is a simple validity check.

Valid codes are **00** - **25**, **99**, and any doubled upper-case letter (**AA**, **BB**, **CC**, **DD**, ... , **ZZ**). The doubled letter codes used by the edit are kept in a look-up table.

Lower case letters are not valid. A combination of number and letter is not valid. Any two letters which are not identical are not valid.

Note that when a doubled letter code is used in a case record, there is no edit that checks to see if the Behavior is coded as benign or uncertain. Likewise, if the Sequence Number is numeric, there is no check that the Behavior is coded as *in situ* or malignant.

The field cannot be empty.

150. **Sex (SEER SEX)**

field involved: Sex (1 digit long)

This is a simple validity check.

Valid codes are **1** - **4** and **9**.

The field cannot be empty.

151. **Sex, Primary Site (SEER IF17)**

fields involved: Primary Site
Sex

This edit checks that primary site codes considered to be "single-sex" are not combined with the opposite sex code.

The edit is skipped for a case record if either field has failed its validity check.

The edit fails when the sex is coded male (**1**) for primary site codes **C510** - **C589** (vulva; vagina; cervix uteri; corpus uteri; uterus, NOS; ovary; other and unspecified female genital organs; placenta).

The edit fails when the sex is coded female (**2**) for primary site codes **C600** - **C639** (penis; prostate gland; testis; other and unspecified male genital organs).

Note that the edit accepts any sex *except* male for the female-only sites, and any sex *except* female is OK for the male-only sites. That is, if the sex is coded as unknown (**9**) and the site is prostate or cervix, the edit does not mind.

The other sex codes (**3**, **4**) are also accepted with any site.

152. Social Security Number (NAACCR)

field involved: Social Security Number (9 digits long)

This is mainly a character check. It also considers one code invalid.

The field can only contain nine numbers. Any other type of character will fail. Fewer than nine numbers will fail.

A zero-filled Social Security number is not valid.

Any other nine numbers, even something suspiciously invalid-looking like **555555555** or **000000001**, will pass the edit.

The field cannot be empty.

153. Spanish/Hispanic Origin (SEER SPANORIG)

field involved: Spanish/Hispanic Origin (1 digit long)

This is a simple validity check.

Valid codes are **0 - 7** and **9**.

The field cannot be empty.

154A. Summary Stage (NAACCR)

field involved: SEER Summary Stage 1977 (1 digit long)

This is a simple validity check.

Valid codes are **0 - 5, 7** and **9**. The field may be empty.

The edit will not accept a code of **6** for a stage of non-localized, NOS.

154B. Summary Stage 2000 (NAACCR)

field involved: SEER Summary Stage 2000 (1 digit long)

This is a simple validity check.

Valid codes are **0 - 5, 7** and **9**. The field may be empty.

155A. Summary Stage 2000, Date of Diagnosis (NAACCR)

fields involved: Date of Diagnosis (year only)
Summary Stage 2000

This edit checks that Summary Stage 2000 is filled for diagnoses made in 2001 and thereafter.

If the year of diagnosis > **2000** (but not **9999**) and Summary Stage 2000 is empty, the edit fails. If the year of diagnosis is unknown (**9999**), the edit skips.

156A. Summary Stage 2000, Regional Nodes Pos (NAACCR)

fields involved: Regional Nodes Positive
Summary Stage 2000

This edit looks for basic compatibility between the positive node status and the Summary Stage 2000 coded. It skips any case record in which the Summary Stage 2000 is regional, NOS (5), distant (7) or unknown/unstageable (9).

The edit questions the following combinations of Summary Stage 2000 and Regional Nodes Positive:

Summary Stage *in situ* (0), localized (1), or regional by direct extension only (2) and at least one Regional Node Positive 01 - 97;

Summary Stage regional to nodes only (3) or regional by direct extension plus regional nodes (4) and no Regional Nodes Positive (00) or it's unknown if any nodes examined were positive (99)*.

* (The combination of Summary Stage 3 or 4 and Regional Nodes Positive 99 produces a warning instead of an error.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and Regional Nodes Positive will indicate a coding error in one of the two data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. ...SEER rules for collection of Regional Nodes Positive included a 2-month time period rule until 1998 when a 4-month rules was implemented. ROADS instructions for Regional Nodes Positive specify to record lymph nodes removed as part of the first course of therapy. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

This edit skips for a case record if either field is empty.

This edit has an over-ride ("SS/Nodes Pos").

157. Summary Stage 2000, Site, Hist, Class (NAACCR)

fields involved: Class of Case
Histologic Type ICD-O-3
Primary Site
SEER Summary Stage 2000

Not all of the general Summary Stage codes (0-5,7,9) are applicable to all sites and histologies. This edit carefully checks that the Summary Stage 2000 field contains a code that is valid for the diagnosis coded.

The edit allows any Summary Stage 2000 code (0 - 5, 7, 9) for any site and histology, with the following exceptions:

ICD-O-3 histologies 8800-9055, 9110-9136, 9141-9508, 9520-9582 cannot be *in situ* (stage 0); codes 1-5, 7, 9 are OK;

the following staging schemes cannot have an *in situ* stage (0); codes 1 - 5, 7, 9 are OK:

heart and mediastinum (C380 - C383, C388)

pleura (C384)

other and ill-defined respiratory sites and intrathoracic organs (C390 - C399)

bones, joints and articular cartilage (C400 - C419)

mycosis fungoides and Sezary syndrome of skin, vulva, penis, scrotum (C440-C449, C510-C519, C600-C601, C608-C609, C632, 9700-9701)

peripheral nerves and autonomic nervous system; connective, subcutaneous, and other soft tissues (C470-C479, C490 - C499)

retroperitoneum and peritoneum (C480 - C488)

retinoblastomas (C692, C699, 9510 - 9514);

the following staging schemes cannot be *in situ* (0), regional by direct extension (2) or have regional node involvement (3, 4); codes 1, 5, 7, 9 are OK:

brain and cerebral meninges (C700, C710 - C719)

other parts of central nervous system (C701, C709, C720 - C729);

inflammatory carcinomas of the breast (C500 - C509, 8530) are at least regional by direct extension, so they cannot be *in situ* (0), localized (1), regional to nodes only (3) or regional NOS (5); codes 2, 4, 7, 9 are OK;

the staging scheme for pituitary gland, craniopharyngeal duct and pineal gland (C751 - C753) cannot have regional node involvement (3, 4); codes 0 - 2, 5, 7, 9 are OK

Kaposi sarcoma (9140, any site) cannot be *in situ* (0) or regional NOS (5); codes 1 - 4, 7, 9 are OK;

Hodgkin and non-Hodgkin lymphomas except mycosis fungoides and Sezary syndrome (9590-9699, 9702-9729, any site) cannot be *in situ* (0) or a specific regional stage (2-4); they can only be localized (1), regional NOS (5), distant (7) or unstaged (9);

further, if multiple node regions were involved for a nodal lymphoma (C778), the disease cannot be localized (1) - only codes 5, 7, 9 are OK;

plasmacytoma NOS (9731), extramedullary plasmacytoma (9734), malignant histiocytosis (9750), Langerhans cell histiocytosis NOS (9751) and unifocal Langerhans cell histiocytosis (9752) (any site) can only be localized (1) or distant (7);

all other hemaopoietic and myeloproliferative diseases except those above (9732, 9733, 9740-9742, 9753-9989) (any site) can only be distant (7);

the staging scheme for other and ill defined sites and unknown primary site (C760-C768, C809, C420-C424, C770-C779, all histologies except 9140, 9590-9699, 9702-9729, 9731-9989) can only be staged 9.

For any death certificate-only case (Class 8, entered at the MCR only), the Summary Stage 2000 must be coded 9. This applies to *all* sites and histologies.

The edit skips for a case record if any of the fields involved is empty.

This edit has NO over-ride. Check the *SEER Summary Staging Manual 2000* carefully to see which codes are valid for each staging scheme.

158. Summary Stage 2000, Site, Hist, Rpt Srce (NAACCR)

fields involved: Histologic Type ICD-O-3
Primary Site
SEER Summary Stage 2000
Type of Reporting Source

This edit does exactly what the preceding edit does, but it uses Type of Reporting Source rather than Class of Case to identify cases that were only "diagnosed" on a death certificate. Everything else is the same.

For any death certificate-only case (Type of Reporting Source=7, entered at the MCR only), the Summary Stage 2000 must be coded 9. There are no exceptions.

The edit skips for a case record if any of the fields involved is empty.

159A. **Summary Stage 2000, TNM M (NAACCR)**

fields involved: SEER Summary Stage 2000
 TNM Clin M
 TNM Path M

This edit checks for basic compatibility between the Summary Stage 2000 code and the AJCC M elements.

The Summary Stage 2000 is checked against only one of the M elements. The pathologic M is used unless it is empty, **X_** or **88**; if the pM is empty, **X_** or **88**, and the clinical M is *not* empty/**X_**/**88**, then the cM is checked against the Summary Stage 2000. After checking for **88**s and choosing whether pM or cM is going to be used by the edit, only the first (leftmost) character of the 2-character M element is used.

The edit questions* these code combinations:

- a Summary Stage 2000 that's anything but distant (**0 - 5, 9**) and M=**1** (distant disease);
- a Summary Stage 2000 that's distant (**7**) and M=**0** (no distant disease).

* (Summary Stage codes **0, 1, 3, 9** produce an outright error with M=**1**; codes **2, 4, 5** produce a warning with M=**1**; Summary Stage **7** with M=**0** produces a warning.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record where the Summary Stage 2000 is empty or both of the M elements are empty; it also skips when both M elements are **88** (not stageable in the *AJCC Cancer Staging Manual, Fifth Edition*).

This edit has an over-ride ("SS/TNM-M").

160A. Summary Stage 2000, TNM N (NAACCR)

fields involved: SEER Summary Stage 2000
 TNM Clin N
 TNM Path N

This edit checks for basic compatibility between the Summary Stage 2000 code and the AJCC N elements.

The Summary Stage 2000 is checked against only one of the N elements. The pathologic N is used unless it is empty, **X_** or **88**; if the pN is empty, **X_** or **88**, and the clinical N is *not* empty/**X_**/**88**, then the cN is checked against the Summary Stage 2000. After checking for **88**s and choosing whether pN or cN is going to be used by the edit, only the first (leftmost) character of the 2-character N element is used.

The edit questions these code combinations:

- a Summary Stage 2000 that indicates no regional node involvement (**0 - 2**) and N=**1 - 3** (regional node involvement);
- a Summary Stage 2000 that indicates regional node involvement (**3, 4**) and N=**0_** (no regional nodes involved).

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record in which the Summary Stage 2000 is coded **5, 7** or **9** or is empty. It skips whenever both of the N elements are empty. It also skips when both N elements are **88** (not stageable in the *AJCC Cancer Staging Manual, Fifth Edition*).

This edit has an over-ride ("SS/TNM-N").

155B. Summary Stage, Date of Diagnosis (NAACCR)

fields involved: Date of Diagnosis (year only)
 SEER Summary Stage 1977

This edit checks that the 1977 Summary Stage is filled in for appropriate diagnosis years (before 2001).

If the year of diagnosis < **2001**, SEER Summary Stage 1977 cannot be empty.

161. Summary Stage, Histology (COC)

fields involved: Date of Diagnosis (year only)
 Histology (92-00) ICD-O-2
 SEER Summary Stage 1977

This edit just checks that the 1977 Summary Stage is coded distant for Letterer-Siwe disease, multiple myeloma and leukemias (using ICD-O-2 codes).

The edit skips for any case record diagnosed in 2001 or thereafter.

If the ICD-O-2 histology=**9722, 9732, 9800 - 9941**, then SEER Summary Stage 1977 must be **7**.

156B. Summary Stage, Regional Nodes Pos (NAACCR)

fields involved: Regional Nodes Positive
SEER Summary Stage 1977

This is the Summary Stage 1977 version of Edit# 156A.

This edit looks for basic compatibility between the positive node status and the Summary Stage 1977 coded. It skips any case record in which the Summary Stage 1977 is regional, NOS (5), distant (7) or unknown/unstageable (9).

The edit questions the following combinations of Summary Stage 1977 and Regional Nodes Positive:

Summary Stage *in situ* (0), localized (1), or regional by direct extension only (2) and at least one Regional Node Positive 01 - 97;

Summary Stage regional to nodes only (3) or regional by direct extension plus regional nodes (4) and no Regional Nodes Positive (00) or it's unknown if any nodes examined were positive (99)*.

* (The combination of Summary Stage 3 or 4 and Regional Nodes Positive 99 produces a warning instead of an error.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and Regional Nodes Positive will indicate a coding error in one of the two data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 1977 has been variously coded using all information available within 2 months of diagnosis or within 4 months of diagnosis. SEER rules for collection of Regional Nodes Positive included a 2-month time period rule until 1998 when a 4-month rule was implemented. ROADS instructions for Regional Nodes Positive specify to record lymph nodes removed as part of the first course of therapy. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

This edit skips for a case record if either field is empty.

This edit has an over-ride ("SS/Nodes Pos").

159B. Summary Stage, TNM M (NAACCR)

fields involved: SEER Summary Stage 1977
 TNM Clin M
 TNM Path M

This is the Summary Stage 1977 version of Edit# 159A. This edit checks for basic compatibility between the Summary Stage 1977 code and the AJCC M elements.

Summary Stage 1977 is checked against only one of the M elements. The pathologic M is used unless it is empty, **X_** or **88**; if the pM is empty, **X_** or **88**, and the clinical M is *not* empty/**X_**/**88**, then the cM is checked against the Summary Stage 1977. After checking for **88**s and choosing whether pM or cM is going to be used by the edit, only the first (leftmost) character of the 2-character M element is used.

The edit questions* these code combinations:

- a Summary Stage 1977 that's anything but distant (**0 - 5, 9**) and M=**1** (distant disease);
- a Summary Stage 1977 that's distant (**7**) and M=**0** (no distant disease).

* (Summary Stage codes **0, 1, 3, 9** produce an outright error with M=**1**; codes **2, 4, 5** produce a warning with M=**1**; Summary Stage **7** with M=**0** produces a warning.)

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 1977 has been variously coded using all information available within 2 months of diagnosis or within 4 months of diagnosis. AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record where the Summary Stage 1977 is empty or both of the M elements are empty; it also skips when both M elements are **88** (not stageable in the *AJCC Cancer Staging Manual, Fifth Edition*).

This edit has an over-ride ("SS/TNM-M").

160B. Summary Stage, TNM N (NAACCR)

fields involved: SEER Summary Stage 1977
 TNM Clin N
 TNM Path N

This is the Summary Stage 1977 version of Edit# 160A. This edit checks for basic compatibility between the Summary Stage 1977 code and the AJCC N elements.

The Summary Stage 1977 is checked against only one of the N elements. The pathologic N is used unless it is empty, **X_** or **88**; if the pN is empty, **X_** or **88**, and the clinical N is *not* empty/**X_**/**88**, then the cN is checked against the Summary Stage 1977. After checking for **88**s and choosing whether pN or cN is going to be used by the edit, only the first (leftmost) character of the 2-character N element is used.

The edit questions these code combinations:

- a Summary Stage 1977 that indicates no regional node involvement (**0 - 2**) and N=**1 - 3** (regional node involvement);
- a Summary Stage 1977 that indicates regional node involvement (**3, 4**) and N=**0_** (no regional nodes involved).

This NAACCR edit includes the following advice for the central registry:

"Most of the time, a discrepancy between SEER Summary Stage and the M code in TNM will indicate a coding error in one of the data items. Check the coding of each field carefully and correct any errors. Occasionally, however, there may be a legitimate discrepancy, most likely due to differences in the time period rules used to code the two items. SEER Summary Stage 1977 has been variously coded using all information available within 2 months of diagnosis or within 4 months of diagnosis. AJCC rules for TNM often stipulate specific test results to be included in coding for clinical and pathological staging separately, and relate time periods of coding to the initiation of therapy. Rules are provided for each primary site. Registries may differ in which rules were used, and when they were used. Ascertain the time period rules used by the registry at the time the case was collected, and verify that the appropriate time period rules were used to code the data items involved. If the discrepancy remains, set the over-ride flag ... to indicate that the case is correct as coded."

The edit skips any case record in which the Summary Stage 1977 is coded **5, 7** or **9** or is empty. It skips whenever both of the N elements are empty. It also skips when both N elements are **88** (not stageable in the *AJCC Cancer Staging Manual, Fifth Edition*).

This edit has an over-ride ("SS/TNM-N").

162. **Surgery, Rad, Surg/Rad Seq (COC)**

fields involved: RX Summ--Radiation
 RX Summ--Scope Reg LN Sur
 RX Summ--Surg Oth Reg/Dis
 RX Summ--Surg Prim Site
 RX Summ--Surg/Rad Seq

The edit checks for basic agreement among (cancer-directed) surgery, radiation and their sequencing field.

The edit is skipped for a case record if any of the fields is empty.

If the summary treatment codes indicate that both surgery and radiation were done, then the sequencing field must specify that both were done. That is, the edit wants these code combinations:

RX Summ Radiation=**1-5** and [RX Summ--Scope Reg LN Sur=**1-8**
 or RX Summ--Surg Oth Reg/Dis=**1-8**
 or RX Summ--Surg Prim Site=**10-90**]

and Rx Summ--Surg/Rad Seq=**2-6** or **9**

If the summary codes indicate that at least one of these treatment modalities was not done, then the sequencing field can only indicate that both were not done. That is, the edit wants these code combinations:

RX Summ Radiation=**0** or [RX Summ--Scope Reg LN Sur=**0**
 and RX Summ--Surg Oth Reg/Dis=**0**
 and RX Summ--Surg Prim Site=**00**]

and Rx Summ--Surg/Rad Seq=**0**

Note that unknown codes are missing from these checks. That is, if the summary radiation code is **9** or all of the (cancer-directed) surgery summaries are **9/99**, then the edit will not look at the sequencing field at all. (There is no code for the sequencing field that indicates it's unknown if both radiation and surgery were done.) Thus, the edit will pass this combination of codes:

RX Summ Radiation=**9** or [RX Summ--Scope Reg LN Sur=**9**
 and RX Summ--Surg Oth Reg/Dis=**9**
 and RX Summ--Surg Prim Site=**99**]

and Rx Summ--Surg/Rad Seq=**0, 2-6, 9**

Note that this edit does not look at any dates, so it is not checking that the sequencing field makes sense in terms of time. If the summary codes indicate that radiation was started *before* cancer-directed surgery while the treatment date fields show that radiation started *after* the surgery, the edit does not mind.

163. Surgery, Reason No Surg (COC)

fields involved: Reason for No Surgery
 RX Summ--Scope Reg LN Sur
 RX Summ--Surg Oth Reg/Dis
 RX Summ--Surg Prim Site

This edit checks for agreement between the "Reason for No" field and the summary (cancer-directed) surgery fields.

The edit is skipped for a case record if any of these fields is empty.

If the summary codes indicate that surgery was not done, then the "Reason for No" code cannot indicate that it was done. That is, the edit wants this code combination:

[RX Summ--Scope Reg LN Sur = **0**
 and RX Summ--Surg Oth Reg/Dis = **0**
 and RX Summ--Surg Prim Site = **00**] and Reason for No Surgery <> **0**

If a summary code(s) indicates that some surgery was done, then the "Reason for No" code must also indicate that it was done. That is, the edit wants this code combination:

[RX Summ--Scope Reg LN Sur = **1-8**
 or RX Summ--Surg Oth Reg/Dis = **1-8**
 or RX Summ--Surg Prim Site = **10-90**] and Reason for No Surgery = **0**

Note that unknown codes are missing from these checks. If it's unknown whether any surgery was done, the "Reason for No" field is not checked and can contain any code. That is, the edit will pass this combination of codes:

[RX Summ--Scope Reg LN Sur = **9**
 and RX Summ--Surg Oth Reg/Dis = **9**
 and RX Summ--Surg Prim Site = **99**] and Reason for No Surgery = **0-2, 6-9**

164A. Surgery, RX Date--Surgery (COC)

fields involved: Histology (92-00) ICD-O-2
 Primary Site
 RX Date--Surgery (year only)
 RX Summ--Scope Reg LN Sur
 RX Summ--Surg Oth Reg/Dis
 RX Summ--Surg Prim Site

This edit checks that the year (cancer-directed) surgery started is not coded in conflict with the surgery summary codes. Keep in mind that the Scope of Regional Lymph Node Surgery is now coded **9** for leukemias (**9800 - 9941**), nodal lymphomas (**C770-C779, 9590-9698, 9702-9717**), brain primaries (**C700, C710 - C719**) and unknown primary site (**C809**); but that these diagnoses were not always limited to code **9** in the past.

If the summary codes indicate that no surgery was done, then the year must be zero-filled to indicate that none was done. That is, the edit wants this combination of codes:

[RX Summ--Scope Reg LN Sur = **0** (or **9** for leukemias, nodal lymphomas, brain primaries, unknown primary)
 and RX Summ--Surg Oth Reg/Dis = **0**
 and RX Summ--Surg Prim Site = **00**] and RX Date--Surgery = **00000000**

If the summary codes indicate surgery was done, then the year can't be zero-filled. The edit wants this code combination:

[RX Summ--Scope Reg LN Sur = **1-9** (or **1-8** for leukemias, nodal lymphomas, brain primary, unknown primary)
 and RX Summ--Surg Oth Reg/Dis > **0**
 and RX Summ--Surg Prim Site ≥ **10**] and RX Date--Surgery <> **00000000**

Note that if the Primary Site Surgery or Surgery of Other... summary codes indicate that it's unknown whether or not surgery was recommended/done (**99, 9**), then the date does not have to be **9**-filled -- it can be any date except **00000000**.

The edit skips any case record in which any of the involved fields is empty.

164B. Surgery, RX Date—Surgery, ICDO3 (COC)

fields involved: Histologic Type ICD-O-3
Primary Site
RX Date--Surgery
RX Summ--Scope Reg LN Sur
RX Summ--Surg Oth Reg/Dis
RX Summ--Surg Prim Site

This is an ICD-O-3 version of the preceding edit. It works exactly like the preceding edit, but leukemias and nodal lymphomas are defined by the ICD-O-3 histology code ranges **9800 - 9989** and **9590 - 9699, 9702 - 9729**.

165. TNM Clin M (COC)

field involved: TNM Clin M (2 characters long)

This is a simple validity check.

Valid codes are:

X_
0_
1_
1A
1B
1C
88

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your M field comes to us containing just an **X** without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the pathologic M edit are identical to these.

The field can be empty. (The validity check skips a case record if the clinical M is empty.)

166. TNM Clin N (COC)

field involved: TNM Clin N (2 characters long)

This is a simple validity check.

Valid codes are:

X_	2_	3_
0_	2A	3A
1_	2B	3B
1A	2C	88
1B		

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your N field comes to us containing just an "X" without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the pathologic N edit are identical to these.

The field can be empty. (The validity check skips any case record where the clinical N is empty.)

167. TNM Clin Stage Group (COC)

field involved TNM Clin Stage Group (2 characters long)

This is a simple validity check.

Valid codes are :

0_	1_	2_	4_
0A	1A	2A	4A
0S	A1	2B	4B
	A2	2C	4C
	1B	3_	88
	B1	3A	99
	B2	3B	OC (That first character is the <i>letter</i> "Oh" -- <i>not</i> the number zero.)
	1C	3C	
	1S		

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your Stage Group field comes to us containing just a zero without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the pathologic Stage Group edit are identical to these.

The description of the ROADS version of this edit appearing in the ROADS Edits Manual lists the code "IS" rather than **1S**. **1S** is the valid code.

The field can be empty. (The edit skips for any case record where the clinical Stage Group is empty.)

Note that the Stage Group field is not checked for consistency against the corresponding Clinical T, N and M fields for the diagnosis coded.

168. TNM Clin Stage Group, TNM Path Stage Group (COC)

fields involved: TNM Clin Stage Group
TNM Path Stage Group

This edit simply checks that if one Stage Group code indicates that the case is not stageable under the AJCC staging system (**88**), then the other code must also indicate this.

That is, if the clinical Stage Group = **88**, then the pathologic Stage Group must = **88**. If the pathologic Stage Group = **88**, then the clinical Stage Group must = **88**.

This is all that the edit checks.

169. TNM Clin T (COC)

field involved: TNM Clin T (2 characters long)

This is a simple validity check.

Valid codes are:

X_	2_
0_	2A
A_	2B
IS	2C
SU	3_
SD	3A
1M	3B
1_	3C
1A	4_
A1	4A
A2	4B
1B	4C
B1	4D
B2	88
1C	

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your T field comes to us containing just a **2** without that second space being filled in, the field will fail the edit.

Note: Codes considered valid by the pathologic T edit are identical to these. The field is not checked against any other field.

The field can be empty. (The edit skips a case record if the clinical T is empty.)

170. TNM Edition Number (NAACCR)

field involved: TNM Edition Number (1 digit long)

This is a simple validity check.

Valid codes are **0 - 5, 8** and **9**.

The field cannot be empty.

Note that there is no edit to check if the appropriate Edition was used to stage the case, given its diagnosis year. We expect that this field records the Edition *actually* used to stage the case.

171. **TNM Path M (COC)**

field involved: TNM Path M (2 characters long)

This is a simple validity check.

Valid codes are:

X_
0_
1_
1A
1B
1C
88

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your M field comes to us containing just a **1** without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the clinical M edit are identical to these.

The field can be empty. (The edit skips any case record where the pathologic M is empty.)

172. **TNM Path N (COC)**

field involved: TNM Path N (2 characters long)

This is a simple validity check.

Valid codes are:

X_	3_
0_	3A
1_	3B
1A	88
1B	
2_	
2A	
2B	
2C	

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your N field comes to us containing just a **3** without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the clinical N edit are identical to these.

The field can be empty. (The edit skips if the pathologic N is empty.)

173. TNM Path Stage Group (COC)

field involved: TNM Path Stage Group (2 characters long)

This is a simple validity check.

Valid codes are :

0_	2_	4_
0A	2A	4A
0S	2B	4B
1_	2C	4C
1A	3_	88
A1	3A	99
A2	3B	OC (That first character is the <i>letter</i> "Oh" -- <i>not</i> the number zero.)
1B	3C	
B1		
B2		
1C		
1S		

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your Stage Group field comes to us containing just a "1" without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the clinical Stage Group edit are identical to these.

The description of the ROADS version of this edit appearing in the ROADS Edits Manual lists the code "IS" rather than **1S**. **1S** is the valid code.

The field can be empty. (The edit skips if the field is empty.)

Note that this field is not checked against the corresponding Pathologic T, N and M fields for the diagnosis coded.

174. TNM Path T (COC)

field involved: TNM Path T (2 characters long)

This is a simple validity check.

Valid codes are:

X_	1A	2_	4_
0_	A1	2A	4A
A_	A2	2B	4B
IS	1B	2C	4C
SU	B1	3_	4D
SD	B2	3A	88
1M	1C	3B	
1_		3C	

Letters entered cannot be lower case.

Note that, even if only a single character is being entered, your data system should be filling in the second character with a space (i.e., "blank filling" the field completely), at least when the case is exported for the MCR. For example, if your T field comes to us containing just a **X** without that second space being filled in, the field will fail the edit.

Note: The codes considered valid by the clinical T edit are identical to these. The field is not checked against any other.

The field can be empty. (The edit skips for a case record if the pathologic T is empty.)

175. TNM-Emptiness Check (MCR-CIMS)

fields involved: TNM Clin M
TNM Clin N
TNM Clin Stage Group
TNM Clin T
TNM Path M
TNM Path N
TNM Path Stage Group
TNM Path T

This is a simple blank check. None of the above fields may be empty for the MCR. Unknown or “not applicable” codes should be filled in when necessary.

If any of the fields is empty, the edit will complain with a long message. It will not indicate which field(s) are empty.

176. Tobacco History (MCR-CIMS)

field involved: Tobacco History (1 digit long)

This is a simple validity check.

Valid codes are **0 - 5** and **9**.

The field cannot be empty. The COC version of this edit allows the field to be empty because it is optional for the COC. The MCR must collect this field for all cases.

Note that this field is not checked against patient age. A 3-year old patient coded as a cigar-smoker would not fail any edit.

177. Type of Report Srce(DC/AO), Date of Dx (SEER IF02)

fields involved: Date of Diagnosis
Date of Last Contact
Type of Reporting Source

For cases first diagnosed at autopsy (or on death certificate*), this edit checks that the diagnosis date is the same as the last contact date (which should be the date of death). Remember that, for diagnoses made at autopsy, the diagnosis date should be set to the date of death, even if the autopsy was performed on a later date.

If Type of Reporting Source indicates autopsy (**6**) or death certificate (**7**), then Date of Diagnosis must be the same as Date of Last Contact.

The edit is skipped for a case record if any of the fields has failed its validity check.

Note that the Class of Case code is not being checked -- just the source of information about the case.

* Although true death certificate-only cases are not reported by hospitals to the MCR, if a code of **7** got into the Type of Reporting Source field for a case, this edit would be checking that case's dates of diagnosis and last contact for agreement.

178. Type of Report Srce(DC/AO), Diag Conf (SEER IF05)

fields involved: Diagnostic Confirmation
Type of Reporting Source

This edit checks that diagnoses made at autopsy were made visually or had a positive microscopic histologic finding. It also checks that it's unknown whether microscopic diagnostic confirmation was obtained for diagnoses first made on a death certificate*.

The edit is skipped for a case record if either field has failed its validity check.

If Type of Reporting Source indicates diagnosis at autopsy (6), then Diagnostic Confirmation must be 1 or 6.

If Type of Reporting Source indicates first diagnosis on death certificate (7), then Diagnostic Confirmation must be 9.

Note that the Class of Case code is not being checked -- just the source of information about the case.

* Although true death certificate-only cases are not reported to the MCR by hospitals, if a code of 7 got into the Type of Reporting Source field for a case, this edit would be checking that case's Diagnostic Confirmation code for a 9.

179. Type of Report Srce(DC/AO), Vit Stat (COC)

fields involved: Type of Reporting Source
Vital Status

This edit checks that patients known to have been autopsied or who have a death certificate* are coded as being dead.

The edit is skipped for a case record if either field has failed its validity check.

If the Type of Reporting Source indicates that diagnosis was first made at autopsy (6) or on death certificate (7), then the Vital Status must indicate that the patient is dead (0).

Note that the Class of Case code is not being checked -- just the source of information about the case.

* Although true death certificate-only cases are not reported to the MCR by hospitals, if a code of 7 got into the Type of Reporting Source field for a case, this edit would be checking that case's Vital Status code for a 0.

180. Type of Reporting Source (SEER RPRTSRC)

field involved: Type of Reporting Source (1 digit long)

This is a simple validity check.

Valid codes are 1 and 3 - 7.

The field cannot be empty.

181. Unknown Site, Laterality (NAACCR)

fields involved: Laterality
Primary Site

This edit checks that Laterality is coded "not a paired site" when the Primary Site is unknown.

If Primary Site=C809 then Laterality must = 0.

182. **Unknown Site, Summary Stage (NAACCR)**

fields involved: Primary Site
SEER Summary Stage 1977

This edit checks that the Summary Stage 1977 is coded “unstageable” when the Primary Site is unknown

If Primary Site=**C809** then Summary Stage 1977 must = **9**.

The edit skips for a case record if the Summary Stage 1977 is empty.

183. **Verify ICDO2 to ICDO3 Conversion (NAACCR)**

fields involved: Behavior (92-00) ICD-O-2
Behavior Code ICD-O-3
Date of Diagnosis (year only)
Histologic Type ICD-O-3
Histology (92-00) ICD-O-2
ICDO3 Conversion Flag
Primary Site

This edit checks that the ICD-O-2 morphology code and ICD-O-3 morphology code are compatible for a case record. It only checks records in which the diagnosis was made before 2001, both ICD-O-2 and ICD-O-3 morphologies (behavior and histology) are filled in, and the ICD-O-3 Conversion Flag indicates that a manual review of the two sets of codes has not been performed (codes **0**, **1**, **2** or empty).

The edit skips if the year of diagnosis > **2000**. It skips if the ICD-O-2 behavior and histology are empty. It skips if the ICD-O-3 behavior and histology are empty. It skips if the ICD-O-3 Conversion Flag is coded **3** (manual review of the morphology codes was done) or **4** (this amounts to the same thing as a code **3**).

The edit uses a look-up table of valid ICD-O-2 codes and the corresponding ICD-O-3 code conversions (histologic type codes plus behavior codes). If the ICD-O-2 morphology coded in the case record is found in the table, then the ICD-O-3 morphology coded in the record is compared with the corresponding codes in the look-up table. When discrepancies between the case record and the look-up table are encountered, different warning messages are produced: "Morph--Type&Behav ICD-O-2 not found in conversion table" if the ICD-O-2 codes in the case are not considered valid; "Morph--Type&Behav ICD-O-3 not found in conversion table" if the ICD-O-3 codes in the case are not considered valid; and "ICD-O-2/ICD-O-3 behavior conflict" if the behavior codes do not match the valid conversions. (The behavior codes are actually compared first; if they conflict, then the edit stops without bothering to check if the histologic type codes conflict.)

The edit tries to take into consideration that the ICD-O "matrix" rule may have been applied (the rule that any valid behavior code may be assigned to a morphology to reflect the cancer's true behavior, even if the morphology code printed in the ICD-O manual does not specifically include that behavior code).

The Primary Site code is also involved in the conversion of some morphologies.

The look-up table used by this edit to check the code conversions is based on the ICD-O-2/ICD-O-3 conversion materials available on the SEER website (<http://seer.cancer.gov/Admin/ConvProgs/>). These are the same conversions used by the MCR on our own case records, except that we convert pilocytic astrocytomas (**9421**) to behavior /**3** rather than /**1**.

184. **Vital Status (COC)**

field involved: Vital Status (1 digit long)

This is a simple validity check.

Valid codes are **0** and **1**.

This is one of the rare coded fields which have no code for "unknown". Because this field records the patient's Vital Status as of the Date of Last Contact entered, it is expected that you must know a specific Vital Status.

The field cannot be empty.

185. **Year First Seen This CA (COC)**

field involved: Year First Seen This CA (4 digits long)

This is a simple date validity check.

Valid codes are any 4-digit number from **1944** to the current year.

There is no code for "unknown". It is expected that you must know the value for this field.

The field cannot be empty.

186. **Year First Seen This CA, Date of DX (NAACCR)**

fields involved: Date of Diagnosis (year only)
Year First Seen This CA

This edit checks that the patient was not first seen at your facility for this cancer before the diagnosis year.

The edit is skipped for a case record if the diagnosis year is coded as unknown (**9999**).

The edit will fail if Year First Seen This CA is < the year coded in Date of Diagnosis.

Note that this edit compares these two years only. Treatment years and last contact year are not involved in this edit.